

**State:** New York **Filing Company:** Independent Health Association  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** IHA 2014 Prior Approval Filing  
**Project Name/Number:** IHA 2014 Prior Approval Filing/

### Filing at a Glance

Company: Independent Health Association  
 Product Name: IHA 2014 Prior Approval Filing  
 State: New York  
 TOI: H21 Health - Other  
 Sub-TOI: H21.000 Health - Other  
 Filing Type: Rate Adjustment pursuant to Section 4308(c)  
 Date Submitted: 07/15/2013  
 SERFF Tr Num: NDPD-129108707  
 SERFF Status: Assigned  
 State Tr Num: 2013070073  
 State Status:  
 Co Tr Num:

Implementation 01/01/2014

Date Requested:

Author(s):

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

Disposition Date:

Disposition Status:

Implementation Date:

State Filing Description:

State: New York  
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### General Information

Project Name: IHA 2014 Prior Approval Filing  
Project Number:  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Employer  
Filing Status Changed: 07/16/2013  
State Status Changed:  
Created By: [REDACTED]  
Corresponding Filing Tracking Number:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Large  
Overall Rate Impact:  
  
Deemer Date:  
Submitted By: [REDACTED]

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:  
2014 IHA Prior Approval Filing for Article 44 HMO products. This submission includes Large Group products.

If you need any additional information or have questions, please call [REDACTED]

### Company and Contact

#### Filing Contact Information

[REDACTED], [REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED]

#### Filing Company Information

Independent Health Association  
511 Farber Lakes Drive  
Buffalo, NY 14221  
[REDACTED]

CoCode: 95308  
Group Code: -99  
Group Name:  
FEIN Number: 16-1080163

State of Domicile: New York  
Company Type: Health Article  
44  
State ID Number: 16-1080163

### Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:

### State Specific

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1. Is a parallel product being submitted for another issuing entity of the same parent organization? Yes/No (If Yes, enter name of other entity, submission date, and SERFF Tracking Number of the parallel file.): No
2. Type of insurer? Article 43, HMO, Commercial, Municipal Coop, or Fraternal Benefit Society: HMO
3. Is this filing for Group Remittance, Statutory Individual HMO, Statutory Individual POS, Blanket, or Healthy New York? Yes/No (If Yes, enter which one.): Yes, Group Remittance.
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 Only
5. Is this a Rate only filing? Yes/No [If Yes, enter one: Commission/Fee Schedule, Prior Approval Rate Adjustment, DBL Loss Ratio Monitoring, Loss Ratio Experience Monitoring/Reporting, Medicare Supplement Annual Filing (other than rate adjustment), Medicare Supplement Refund Calculation Filing, Timothy's Law Subsidy Filing, Sole Proprietor Rating, 4308(h) Loss Ratio Report, 3231(e) Loss Ratio Report, Experience Rating Formula, or Other with brief explanation.): Yes, Prior Approval Rate Adjustment
6. Does this submission contain a form subject to Regulation 123? Yes/No (If Yes, provide a full explanation in the Filing Description field.: No
7. Did this insurer prefile group coverage for this group under Section 52.32 prior to this filing? Yes/No (If Yes, enter the state tracking number assigned and the effective date of coverage.): No
8. Does this submission contain any form which is subject to review by the Life Bureau, the Property Bureau or both? Yes/No (If Yes, identify the forms, the Bureau, the date submitted, and the SERFF file number.): No
9. Does this filing contain forms that replace any other previously approved forms? Yes/No (If Yes, identify the form numbers, the file number, and the date of approval of the forms being replaced in the Filing Description field.): No
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, 2013060183, NDPD-129096605

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State Tracking #:

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Company Tracking #:

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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):
Independent Health Association	Increase	2.700%	2.700%	\$8,308,358	11,671	\$313,381,331	-28.710%	9.345%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	51,206							
Policy Holders:	11,671							

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## Rate Review Detail

### COMPANY:

Company Name: Independent Health Association  
 HHS Issuer Id: 70552  
 Product Names: 2014 IHA Prior Approval  
 Trend Factors:

### FORMS:

New Policy Forms:  
 Affected Forms: All Existing  
 Other Affected Forms: All Existing

### REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual  
 Member Months: 578,796  
 Benefit Change: Increase  
 Percent Change Requested: Min: -28.71 Max: 9.345 Avg: 2.7

### PRIOR RATE:

Total Earned Premium: 307,860,520.72  
 Total Incurred Claims: 254,136,862.38  
 Annual \$: Min: 438.20 Max: 699.61 Avg: 608.83

### REQUESTED RATE:

Projected Earned Premium: 292,952,454.73  
 Projected Incurred Claims: 248,468,597.89  
 Annual \$: Min: 454.10 Max: 716.70 Avg: 624.81

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## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Material		New		A44_L_Manual_2014_Rev_2013_07_15.pdf,

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## Supporting Document Schedules

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

<b>Satisfied - Item:</b>	Final Notice of Proposed Rate Adjustment
<b>Comments:</b>	
<b>Attachment(s):</b>	Commercial Employers - 2014 Proposed Premium Notice - FINAL 7-4-2013.pdf Commercial Group Subscribers - 2014 Proposed Premium Notice - FINAL 7-4-2013.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Initial Notice of Proposed Rate Adjustment
<b>Comments:</b>	
<b>Attachment(s):</b>	Commercial Employers - 2014 Proposed Premium Notice - FINAL 7-4-2013.pdf Commercial Group Subscribers - 2014 Proposed Premium Notice - FINAL 7-4-2013.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Redacted Documents for Web Posting
<b>Comments:</b>	
<b>Attachment(s):</b>	IHA Act Memo 2014 Large Group 20130712_Redacted.pdf Exhibit 1_Redacted.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 2 - Summary of Average Claim Trend and Administrative Expenses
<b>Comments:</b>	

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<b>Attachment(s):</b>	Exhibit 2.pdf Exhibit 2.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 3 - Narrative Summary
<b>Comments:</b>	
<b>Attachment(s):</b>	NARRATIVE SUMMARY - IHA Group 07032013.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 4 - Part B - Summary of Proposed Percentage Rate Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_4B_IHA_LG.pdf Exhibit_4B_IHA_LG.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 5 - Part B - Distribution of Contracts Affected by Proposed Rate Adjustments
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_5B_IHA_LG.pdf Exhibit_5B_IHA_LG.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 6 - Summary of Policy Form and Product Changes
<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_6_IHA.pdf Exhibit_6_IHA.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Standard Exhibit 7 - Historical Data
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<b>Comments:</b>	
<b>Attachment(s):</b>	Exhibit_7_IHA_LG.pdf Exhibit_7_IHA_LG.xls
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Unified Rate Review Template
<b>Comments:</b>	
<b>Attachment(s):</b>	plan_management_data_templates_unified - Final.xlsm URRT.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

## NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

As of 6/24/13

**NOTE: The Department requests that any calendar year 2014 rate filing submitted pursuant to section 3231(e)(1) or 4308(c) of the NYIL for grandfathered individual or small group products, or for large group community rated products, not be submitted until July 15, 2013. This does not apply to Medicare Supplement rate adjustment filings. Resources during the first part of July are needed to complete the review of the Exchange filings. Pre-filings of the Narrative and Initial Notice can be submitted prior to July 15, 2013.**

Clarification of the rate adjustment filing process for calendar year 2014 large group community rated products:

1. The changes due to ACA impact large group to a much lesser degree than small group. Most of the market reforms do not apply to large group, such as standard rating regions, standard census tiers and relationships, actuarial value ranges, and model contract language.
2. The 2014 rate adjustment process for large group community rated products is the same as for 2013. This checklist applies to large group community rated rate adjustment filings.
3. Each HMO and Article 43 insurer will need to submit pursuant to section 4308(c) a rate adjustment filing for large group community rated products. This filing will reflect rate changes due to experience and claim trend. This filing can include revisions to existing rating regions and existing area factors, but cannot include a new service area that has not already been approved. This filing cannot include contract language changes, or a new form or rider, which has not already been approved.
4. If there will also be contract language changes, or a new form or rider, the insurer will also have to submit a form and rate filing for the contract changes using the "Normal Pre-Approval" SERFF filing type code. The rates included in the form and rate filing must reflect only the impact of the contract language changes to existing benefits, or introduction of a new benefit, and must be consistent with the rate level submitted in the rate adjustment filing. A final decision on the form and rate filing will need to be deferred until the rate adjustment decision has been made so that the rate level of the rates included in the form and rate filing are consistent with the rates approved in the rate adjustment filing.

The changes are summarized below:

1. For the revised 4/8/13 standard exhibits 4 and 5, the weighted averages are to be based on annualized premiums (not by members or contracts). In Exhibit 5, the distribution of the size of rate change is still shown by members or contracts.
2. A draft copy of the Narrative and Initial Notice should be submitted to the Department for prior review using the "Prior Approval Prefiling" filing type code. Previously only the initial notice was mentioned in the material below.
3. The Department is requesting that the rate pages section of the Rate Manual also be submitted as an Excel workbook(s), in addition to submitting the Rate Manual as a PDF file(s).
4. We understand that the HHS HIOS system will only accept the Unified Rate Review Template (URRT) Excel workbook and will no longer accept the prior Part I Justification workbook. For small group and individual market filings, the completed URRT submitted to HHS needs to be included with the filing submission. Questions about completing the URRT need to be directed to HHS/CCIIO. For a large group community rated filing, where HHS does not require completion of the URRT, the insurer is to complete Worksheet 1 of the URRT for each large group rating pool and include the URRT(s) in the rate submission. The prior Part II Justification is now the Consumer Disclosure Form item on the Supporting Documentation tab.

This checklist applies to rate adjustment filings for grandfathered small group and individual products and policyholders as that term is defined by HHS in their regulations. A different checklist and different filing type codes will be developed for future non-grandfathered small group and individual rate adjustment filings. This checklist also applies to rate adjustment filings for large group community rated products pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law.

## 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

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 and would be used for all form and rate filings, form only filings, experience rating formula filings, or commercial insurer rate only filings other than filings submitted pursuant to Section 3231(e)(1), or Article 43 Corporation and HMO rate only filings other than filings submitted pursuant to Section 4308(c).

## 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

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 2013; a benefit revision is submitted January 2013 to be effective July 1, 2013; this form and rate filing can include rolling rate tables for third and fourth quarter 2013, but not beyond fourth quarter 2013).

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

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

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

It is recommended that a rate adjustment submission not be submitted more than 180 days prior to the proposed rate effective date. It is recommended that a rate adjustment submission not be submitted less than 125 days prior to the proposed effective date since there is a high probability that a decision on such a filing will not occur in time for the company to send the required final notice to the first renewal cohort affected by the rate adjustment filing. If a company can not send the required final notice at least 60 days in advance of the rate change date for a particular renewal cohort, then the rate change implementation date for such renewal cohort will need to be deferred. Contract terms will dictate whether the rate change can be deferred to a later implementation date for that renewal cohort (e.g., for the July 2013 renewal cohort, deferring the rate change to August 2013, while retaining the next rate change date as July 2014), or deferring implementation of the newly approved rates to a later renewal cohort (e.g., assuming quarterly rolling rates are used: renewing the July 2013 renewal cohort using the previously approved second quarter 2013 rate tables, and implementing the newly approved rates with the August 2013 renewal cohort).

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

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

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

**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**

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

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

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

**NOTE:** Parts I (URRT) and II (Consumer Disclosure) of the HHS Justification are required for all market segments and for all section 3231(e)(1) or 4308(c) rate submissions, whether or not required to be sent to HHS. See the section “HHS Justification Parts I and II” below for guidance. (This refers to the material that an insurer is required to submit to HHS for a rate adjustment filing or what would be submitted to HHS if the “subject to review” threshold was exceeded by this filing.)

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
<b>DEFINITIONS</b>		<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 and the Regulation 146 pool (11 NYCRR 361) to the extent these programs are continued. Incurred claims include 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. The ACA assessments are considered as part of administrative expenses.</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> </ul>	

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		<p>e. <b>Product street name</b> refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department.</p> <p>f. <b>Rate applicability period</b> refers to the length of time in which the rates in a rate table are assumed to remain in effect.</p> <p>(i) Example 1: A non-rolling rate table is developed to be effective January 1, 2013 and is expected to be revised January 1, 2014. The rate applicability period for this table is January 1, 2013 through December 31, 2013.</p> <p>(ii) Example 2: A quarterly rolling rate table is developed for issues and renewals in January – March 2013 and incorporates a 12 month rate guarantee period. The rate applicability period for this table is February 15, 2013 (mid renewal date) through February 14, 2014. If all policyholders must have a first of the month effective date, then the rate applicability period would be considered as February 1, 2013 through January 31, 2014.</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</p>	
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		<p>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 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>		<p>a. All rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period.</p> <p>c. Notwithstanding the above, a large group HMO rate filing can include rolling rates for up to a 24 month period (e.g., 8 quarterly rolling rates).</p>	<p>Quarterly rolling rates for 4 Quarters are included in this filing across multiple exhibits.</p>
<p><b>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</b></p>		<p>a. The rate adjustment filing must include all community rated policy forms within a given market segment 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. This refers to all grandfathered small group products, or all grandfathered individual products, or all large group community rated products.</p> <p>b. A company can revise a previously approved non-rolling rate table provided that:</p> <p>(i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or</p> <p>(ii) The proposed effective date of the rate table is at least 6 months after the effective date of the current rate table, the contract language permits revising the rate table in accordance with such rate filing, and all policyholders that received a final 60 day notice about the approved rates from the previously approved rate adjustment filing have also received the rate change approved from the previously approved rate adjustment filing.</p> <p>c. A company can revise rate tables included in a previously approved rolling rate filing provided that: (i) the rate tables being revised were never implemented, (ii) 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</p>	<p>Supporting Documents - Exhibit 6</p> <p>Supporting Documents - Actuarial Memorandum Page 7</p>

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		<p>submitted and approved that included quarterly rolling rate tables for 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2012. The company can not revise the 1<sup>st</sup> and 2<sup>nd</sup> quarter 2012 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3<sup>rd</sup> and 4<sup>th</sup> quarter 2012 and 1<sup>st</sup> and 2<sup>nd</sup> quarter 2013.) The Department may waive these requirements if the company can demonstrate to the Superintendent’s satisfaction that the solvency of the corporation is threatened.</p>	
<p><b>STANDARD EXHIBITS 1 - 7</b></p>	<p>Introduction</p>	<p>a. 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 the first tab of each Excel workbook is to be used for data entry; if an entry is made on another tab of the workbook, an objection letter will be sent requesting a corrected exhibit.</p> <p>b. As a general rule, enter one value for one cell. For example, one company name for the cell “Company submitting the rate adjustment request”, one NAIC code for the cell “Company NAIC Code”, and one SERFF number for the cell “SERFF Tracking Number.”</p> <p>c. When there is a drop down list provided, an entry from the list is to be chosen. If no entry on the list is exactly what needs to be selected, choose the closest entry from the drop down list.</p> <p>d. Multiple policy form numbers may be entered into one cell of Exhibit 4, Exhibit 6, and Exhibit 7, if:</p> <p>(i) For Exhibit 4, the multiple policy forms are for the same market segment and the same product, and have the same rate increases;</p> <p>(ii) For Exhibit 6, the multiple policy forms are submitted under the same SERFF number indicated for the same product and in the same market segment; or</p> <p>(iii) If the multiple policy forms have the same results for all the other columns indicated on the exhibit.</p>	
<p><b>Exhibit 1</b></p>		<p><b>General information about the rate adjustment submission.</b></p> <p>a. The format for this exhibit is fixed. Fill in the various information fields; the information being requested is indicated on the exhibit.</p> <p>b. Indicate the company type using the drop down list: Article 42 Accident and Health company (A&amp;H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&amp;C – 41), and Article 43 Non-Profit Medical and Dental Indemnity or Health and Hospital Service Corporations (Not for Profit – 43).</p> <p>c. Indicate the organization type (Org Type), for profit or not for profit, by using the drop down list.</p> <p>d. Item D – the “new rate effective date” must be a realistic implementation date given the review time allowed the Department and the requirement of the 60 day</p>	<p>Supporting Documents - Exhibit 1</p>

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		<p>final rate notice. This date would usually be the first date the proposed rates would affect renewing policyholders. So a 1/1/2014 effective date would imply that the first renewal cohort affected by the rate submission would be January 2014.</p> <p>e. Item F.1 – a rate adjustment filing where the rate manual also includes rate adjustments for unapproved contract language changes will be rejected.</p> <p>f. This exhibit must be submitted as an Excel file and as an Adobe PDF file.</p>	
<b>Exhibit 2</b>		<p><b>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</b></p> <p>a. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed; insert more rows as needed. Only use the first tab for data entry.</p> <p>b. Use a separate row to enter information for each combination of market segment/rating pool included in this rate adjustment application. Use the drop down list to enter the market segment. Enter a description of the rating pool in the column indicated; if the rating pools vary by rating region, the rating pool identifier should include a region identifier.</p> <p>c. Information is for medical base plans and all associated riders combined.</p> <p>d. The average claim trend is the average annualized claim trend for that market segment/rating pool used in the applicable rate adjustment filing to project the source data forward to the applicable rate applicability period.</p> <p>e. The administrative expense components incorporated into the proposed rates are to be entered as a percentage of gross premium and as a per member per month amount.</p> <p>f. Enter the data for the rate period included in this rate adjustment filing. This refers to the various non-claim expense components included in the proposed rates and the average annualized claim trend assumed.</p> <p>g. Enter the data for the rate period included in the immediately prior rate adjustment filing (i.e., a section 3231(e)(1) or 4308(c) rate adjustment filing). This refers to the various non-claim expense components included in the proposed rates submitted with this prior filing and the average annualized claim trend assumed in this prior filing. If there is no immediately prior rate adjustment filing, enter the data assumed in the initial or prior form and rate filing.</p>	Supporting Documents - Exhibit 2
<b>Exhibit 3</b>	Circular Letter No. 12 (2011)	<p><b>Narrative Summary.</b></p> <p>a. As indicated in Circular Letter No. 12 (2011), a draft of the narrative summary should be submitted for review by the Department prior to the rate adjustment submission. This draft should be submitted via SERFF using the “Prior Approval Prefiling” filing type code.</p> <p>b. The format of the exhibit is illustrative, but must include the required material. The exhibit may be submitted as a Word document file, an Adobe PDF file, or an Excel</p>	Supporting Documents - Exhibit 3

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		<p>file. If submitted as a Word or Excel file, also submit another version in PDF format.</p> <p>c. The narrative summary is to explain the reason(s) for the proposed rate adjustment. The purpose of the narrative summary is to provide a written explanation to the company’s policyholders and subscribers to help them understand why a rate increase is needed.</p> <p>d. The narrative summary will be a public document.</p> <p>e. It is suggested that once reviewed by the Department, the company post the narrative summary to a location on its website that is publicly available, that is, a location that can be viewed without the need for entering a user ID and password. Links should be provided on key pages of the company’s website so that the information may be easily located. Any change(s) to the narrative summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified. Narrative summaries should remain on the company’s website for at least 12 months past the proposed effective date of the rate submission.</p> <p>f. The narrative summary should include, but not be limited to, the following information:</p> <p>(i) The name of the company submitting the rate adjustment request, the NAIC code number for the company, and the SERFF number for the rate application.</p> <p>(ii) A summary of the proposed rate adjustments.</p> <p>(iii) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect policyholders in a certain market segment (e.g., small group), or with certain products (indicate the “street name” of the products affected), or only a certain renewal cohort (e.g., policyholders renewing from period mm/dd/yyyy – mm/dd/yyyy).</p> <p>(iv) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders. Examples:</p> <p>i. Non guaranteed rate structure: all policyholders will receive the rate adjustment on mm/dd/yyyy.</p> <p>ii. A rate structure with a 12 month rate guarantee: a policyholder will receive the rate adjustment on the policyholder’s next anniversary on or after mm/dd/yyyy.</p> <p>(v) The number of policyholders and members affected by the proposed rate adjustments. This can be aggregated across all market segments and products included in the rate adjustment submission.</p> <p>(vi) An explanation, in plan language, as to why it is necessary to request such rate change(s). As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate</p>	
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		<p align="center">explanation for each such product type. Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	
<p><b>Exhibit 4</b></p>		<p><b>Summary of Proposed Percentage Rate Change to Existing Rate.</b></p> <p>a. There are four different versions of this exhibit as indicated below. Not all versions may be required for a given rate filing. Only the version(s) required need be attached to the Supporting Documentation Tab.</p> <p>(i) Part A – Base Medical Plan information when a <u>Non-Rolling</u> Rate Structure is used.</p> <p>(ii) Part B – Base Medical Plan information when a <u>Rolling</u> Rate Structure is used.</p> <p>(iii) Part C – Drug Rider information when a <u>Non Rolling</u> Rate Structure is used.</p> <p>(iv) Part D – Drug Rider information when a <u>Rolling</u> Rate Structure is used.</p> <p>b. The information to be shown in this exhibit pertains to the market segments and products included in the rate adjustment filing. Use the drop down list to enter the market segment.</p> <p>c. This exhibit must be submitted as an Excel file and as an Adobe PDF file. The format of the exhibit is fixed, insert more rows as needed. Only use the first tab for data entry.</p> <p>d. This exhibit is to summarize the proposed percentage rate changes. The percentage rate change is the percentage change from the rate the subscriber is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which are not being revised by the current rate application) to the proposed rate that this subscriber would be paying at the subscriber’s next rate change date according to the new rate application.</p> <p>Example 1: the rate structure is quarterly rolling rates, has a 12 month rate guarantee period, and the rate adjustment application is for second quarter 2013 issues and renewals. The rate change would be the percentage change from the second quarter 2012 rates to proposed second quarter 2013 rates.</p> <p>Example 2: the rate application includes quarterly rolling rates for each quarter of calendar year 2013. The prior rate application included quarterly rolling rates for each quarter of 2012. Rates include a 12 month rate guarantee period. The current rate application is submitted July 2012 before all the third and fourth quarter 2012 renewals have taken place. The proposed percentage change for fourth quarter 2013 would be the change from the fourth quarter 2012 rates to the proposed fourth quarter 2013 rates.</p> <p>e. If the subscriber will need to change to a different plan design at renewal (i.e., a 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</p>	<p>Supporting Documents - Exhibit 4C</p>

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

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		<p>placeholder with the applicable “as of” date for the counts entered.</p> <p>f. The Weighted Average % is to be developed based on the distribution of annualized premium as of the same “mm/dd/yy” date for that market segment/rating region/product.</p> <p>g. At the end of each market segment enter a Market Segment Total row indicating the member/contract counts in total and by rate change column, the total annualized premium, and the Weighted Average % for all rating regions/products in that market segment combined.</p> <p>h. The percentage rate change reflects the expected change in premium rate that would apply to that subscriber/contract holder on that subscriber/contract holder’s next rate change date according to the new rate application. This would reflect the percentage rate change from the rate the contract holder is currently paying (or currently scheduled to be paying at the next rate change date for changes already approved or deemed approved by a prior rate application and which is not being revised by the current rate application) to the proposed rate that this contract holder would be paying at the contract holder’s next rate change date according to the new rate application The rate change reflects the impact of the base medical plans and all riders applicable to that contract.</p> <p>i. Enter in Part A the information for the various products that use a <u>non-rolling</u> rate structure.</p> <p>j. Enter in Part B the information for the various products that use a <u>rolling</u> rate structure. Separate rows are to be used for each rolling rate cohort. For example, if the rate submission is for quarterly rolling rate tables for first, second, third and fourth quarter 2013, then separate rows would be used to enter information for each of these four quarters. The distribution shown for a particular quarter would reflect only those policyholders renewing in that particular quarter.</p>	
<p><b>Exhibit 6</b></p>		<p><b>Summary of Policy Form and Product Changes.</b></p> <p>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.</p> <p>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.</p> <p>c. List all rate filings that have been approved since the prior Section 3231(e)(1) or Section 4308(c) rate filing that impact the percentage rate change of the policyholders affected by this rate adjustment filing. The actuarial memorandum should include a brief description of such changes, when the changes were</p>	<p>Supporting Documents - Exhibit 6</p>

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

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		<p>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> <ul style="list-style-type: none"> <li>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.</li> <li>j. The expected loss ratio is the loss ratio incorporated into the proposed rate tables for each base medical policy form (and the entire rating pool) and includes the impact of associated riders and reflects the impact of the proposed rate changes. Loss ratio is calculated on a New York statewide basis. For a rolling rate structure, enter the expected loss ratio incorporated into the rate tables of the first rolling rate period of the rolling rate structure.</li> <li>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.             <ul style="list-style-type: none"> <li>(i) Each experience period is to be for 12 months (or shorter if a new form).</li> <li>(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.).</li> <li>(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.</li> <li>(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, unless the Department has given prior approval to use a shorter period (but no shorter than 2 months). The actuarial memorandum is to provide a clear description of how these incurred claims were developed for each experience</li> </ul> </li> </ul>	
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**Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law**

		<p>period and how many months of claim run-out were reflected in the development of the incurred claims.</p> <p>(v) Loss ratio report refunds or refunds pursuant to Regulation 146 are to have no impact on the earned premiums or standardized premiums shown. Such refunds do not reduce the earned premiums or resultant standardized earned premiums.</p> <p>l. Enter the average annual composite medical trend assumption used in the proposed rate development for each base medical policy form (including impact of associated riders). Enter the annual utilization and unit cost trend components included in the composite trend factor shown, as well as any other component such as for case mix or intensity (identify and discuss and justify any such other component in the actuarial memorandum along with the utilization component and unit cost component).</p> <p>m. The actuarial memorandum is to include a clear description of how the standardized earned premiums for each experience period were developed from the earned premiums for the applicable experience period, and include documentation and supporting exhibits showing how the standardized premiums were developed for each experience period. A numerical example illustrating the development methodology for one non-rolling rate product and one rolling rate product included in the rate filing is to be included as part of the actuarial memorandum, as applicable. The same standard rate level is used for all of the experience periods.</p> <p>n. If the rating differential between the New York rating regions is being revised with this rate filing, separate rows are to be included for each rating region, each permitted aggregation of rating regions, and for all rating regions combined, and the rating pool identifier is to include a rating region identifier.</p>	
<p><b>ACTUARIAL MEMORANDUM</b></p>	<p>11NYCRR 52.40(a)(1)</p>	<p>Actuarial qualifications:</p> <p>a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and</p> <p>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</p>	<p>Supporting Documents - Actuarial Memorandum</p>
<p>Justification of Rates</p>	<p>§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p>	<p>a. Description of proposed changes in rates, including the following:</p> <p>(i) The member (or contract) weighted average proposed percentage change over the current rates charged to each renewal cohort of policyholders for each base medical policy form, including the impact of all associated riders available to 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</p>	<p>Supporting Documents - Actuarial Memorandum</p>

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		<p>information for percentage rate changes implemented during the prior 24 months.</p> <p>(ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3<sup>rd</sup> quarter 2013. The change from each of the 2<sup>nd</sup> quarter 2013 rolling rate tables to the corresponding 3<sup>rd</sup> quarter 2013 rolling rate table is to be indicated.) The proposed percentage change between each succeeding rolling rate table is also to be indicated.</p> <p>(iii) For the 24 month period prior to the effective date of the earliest rate table included in the rate adjustment filing, indicate the aggregate (medical plus riders) percentage change between the successive non-rolling rate tables. For a rolling rate structure, indicate the aggregate (medical plus riders) percentage change between each of the successive rolling rate tables (e.g., for a quarterly rolling rate structure, the percentage change between each of the successive quarterly rate tables).</p> <p>(iv) The percentage change due to any change in the expected loss ratio incorporated into the proposed rate tables from the prior rate filing for such base medical policy form or rider. Indicate the expected loss ratio incorporated into the current rate tables, the expected loss ratio incorporated into the proposed rate tables, the impact on the percentage change in items (i) and (ii) above due to this revision in the expected loss ratio, and the reason(s) and justification for the change in the pricing expected loss ratio.</p> <p>(v) The percentage change due to any change to the tier structure relationships included in this rate filing and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vi) The percentage change due to any change to the factor used to convert per member per month results to per single employee results included in this rate filing, and the impact of such change on the percentage changes in items (i) and (ii) above. Include justification for such changes.</p> <p>(vii) The percentage change due to variance in the prior incurred claim cost per member per month estimate and the impact of such variance on the percentage changes in items (i) and (ii) above. Discuss the reasons contributing to this variance and include an exhibit showing how this variance and the percentage</p>	
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**Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 3231(e)(1) or Section 4308(c) of the New York Insurance Law**

		<p>impact of this variance were developed.</p> <p>(viii) Changes to any of the rating differentials between the various rating regions included in this rate filing. If the rating differential between the rating regions was changed, include (a) a listing of the composition of each rating region, (b) the percentage change impact on each such rating region, and (c) justification for each such change between the rating region differentials. If the composition of any rating region is being changed with this filing, indicate (a) the current and proposed composition of the affected rating regions, (b) the percentage change impact on each of the affected rating regions, and (c) justification for the proposed change in the rating region composition.</p> <p>b. If new benefit options are being added to an existing rate table (such as additional copays or deductibles): (a) clearly indicate the additions being made, (b) include in the actuarial memorandum, a statement that the already approved contract language includes the new benefit options being added, (c) provide appropriate actuarial justification for the additional rating factors, and (d) submit a copy of the approved contract language pages and a copy of the Department’s approval letter and clearly indicate how the approved contract language covers the new benefit options being added to the existing rate table.</p> <p>c. Include the following (year over year exhibit):</p> <p>(i) For each non-rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission.</p> <p>(ii) For each rolling rate table: the current rate for each rating tier, the proposed rate for each rating tier, and the dollar and percentage change for each renewal cohort from the current rate to the proposed rate for each rate table, rating tier, and benefit option for each policy form and rider form included in the rate submission. (Example: the rate submission includes new rate tables for third and fourth quarter 2013 and first and second quarter 2014. Rates are for 12 month periods. Show the rates for the third quarter 2012, the proposed rates for the third quarter 2013, and the dollar and percentage change from third quarter 2012 to the proposed third quarter 2013 rates. Show a similar table for the proposed fourth quarter 2013, and first and second quarter 2014 rates as well.)</p> <p>d. Discuss the standard premium development used in Standard Exhibit 7. See 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>	
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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) 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.</li> <li>(iii) Discuss the credibility of such source data.</li> <li>(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.</li> </ul> <p>f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <ul style="list-style-type: none"> <li>(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.</li> <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> </ul>	
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**NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES**

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		<ul style="list-style-type: none"><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, to the extent these programs are continued..</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 for pooling large claims.</li><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</li></ul>	
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		<p>the aggregated policy forms. Any assumed variation in utilization between policy forms within a permitted aggregation of policy forms must be based solely on the benefit differential, must assume that the same population of insureds selects each benefit option within the permitted aggregation of policy forms, and cannot be based on differences due to age, sex, health status or industry among the members selecting a particular benefit option within the aggregated policy forms.</p> <p>j. If the percentage rate change by rating region differs, the default assumption is that the rating regions are not aggregated for rate setting purposes. In order for a company to claim that certain rating regions are aggregated for rate setting purposes, it is necessary to include an actuarial demonstration that the rate changes were developed assuming the same insured population in each of the aggregated rating regions, and that the differences in the percentage rate changes are not due to differences in the age, sex, health status, or industry distributions of the members in each of the aggregated rating regions.</p> <p>k. Discuss any significant change in the non claim expense components indicated on Standard Exhibit 2 between the prior rate adjustment filing and this rate adjustment filing, including any item where the \$mpm value exceeds \$1 and where the \$mpm value changed by more than 10% between the prior filing and the current filing. Discuss the source for the non-claim expense components indicated on Standard Exhibit 2 for the current rate filing and, for the percentage of gross premium values, how the proposed rate change was reflected in the development of those percentage of gross premium factors (e.g., as premiums increase the percentage of premium should decrease for an expense that is not directly tied to premium). Discuss any revision to the expense allocation basis that has occurred since the last rate adjustment filing.</p>	
<p>Minimum Loss Ratio Requirements</p>	<p>§3231(e)(1)(B) §4308(c)(3) 11NYCRR52.45(i) 11NYCRR59.5(b)</p>	<p>a. The minimum loss ratio for community rated products, other than the official Medicare Supplemental products, is as specified in Section 3231(e)(1)(B) or 4308(c)(3)(A) of the New York Insurance Law, as amended by Chapter 107 of the Laws of 2010.</p> <p>b. The minimum loss ratio for the official Medicare Supplemental products is: (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 (ii) Article 42 companies: as specified in Section 52.45(i) of Regulation 62 (11 NYCRR 52).</p>	<p>Supporting Documents - Actuarial Memorandum</p>
<p>Actuarial Certification</p>	<p>11NYCRR 52.40(a)(1)</p>	<p>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</p> <p>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.</p> <p>c. The expected loss ratio incorporated into the proposed rate tables meets the minimum requirement of the State of New York by permitted aggregation of</p>	<p>Supporting Documents - Actuarial Memorandum</p>

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		<p>policy forms within each permitted aggregation of rating regions. Specify the expected loss ratio incorporated into the proposed rate tables for each permitted aggregation of policy forms within each permitted aggregation of rating regions.</p> <p>d. The benefits are reasonable in relation to the premiums charged.</p> <p>e. The rates are not unfairly discriminatory.</p>	
<p><b>REVISED RATE MANUAL PAGES</b></p>	<p>11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)</p>	<p><b>Rate Manual.</b></p> <p>a. Table of contents.</p> <p>b. Rate pages, including a page indicating the composition of each rating region.</p> <p>c. Insurer/corporation name on each consecutively numbered rate page.</p> <p>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</p> <p>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</p> <p>f. Description of revised rating classes, factors and discounts, as applicable.</p> <p>g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design.</p> <p>h. Commission schedule(s) and fees.</p> <p>i. Underwriting guidelines and/or underwriting manual, to the extent applicable.</p> <p>j. Expected loss ratio(s).</p> <p>The Rate Manual is to be attached to the Rate Schedule tab as an Adobe PDF file; if more than one file is needed, each file should be properly labeled to indicate the contents of the file. The Department is requesting that the rate pages section of the manual also be submitted as an Excel workbook(s).</p>	<p><a href="#">Rate/Rule Schedule - A44_L_Manual_2014_Rev_2013_07_15.pdf</a></p>
<p><b>NOTICES TO POLICYHOLDERS Initial &amp; Final</b></p>	<p>§3231(e)(1)(A) §4308(c)(2) Circular Letter No. 12 (2011)</p>	<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.</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><a href="#">Supporting Documents - Final Notice of Proposed Rate Adjustment &amp; Initial Notice of Proposed Rate Adjustment</a></p>

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<p><b>HHS JUSTIFICATION PART I (Unified Rate Review Template) AND PART II (Consumer Disclosure)</b></p>	<p>PPACA §1003</p>	<ol style="list-style-type: none"> <li>a. This refers to the material that an insurer is required to submit to HHS for a rate adjustment filing or what would be submitted to HHS if the “subject to review” threshold was exceeded by this filing.</li> <li>b. For every rate submission pursuant to section 3231(e)(1) or section 4308(c) of the New York Insurance Law, the insurer is to submit Parts I and II of the U.S. Department of Health and Human Services (HHS) Justification, whether or not such justification material is required to be submitted to HHS.</li> <li>c. This requirement applies to large group community rated products as well as to small group and individual products, and to non-grandfathered and grandfathered products, but this requirement does not apply to a product type that would never require such justification material to be submitted to HHS (for example: Medicare Supplemental products, stand-alone dental products).</li> <li>d. The Part I justification material is to be prepared using the Excel Unified Rate Review Template and instructions provided by HHS. For a large group community rated filing, the insurer need only complete Worksheet 1 of the Unified Rate Review Template for each large group rating pool and include the URRT(s) in the rate submission.</li> </ol>	<p><a href="#">Supporting Documents - Unified Rate Review Template</a></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> <ol style="list-style-type: none"> <li>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).</li> <li>b. The Department will accept redaction of only the following information in the rate application:             <ol style="list-style-type: none"> <li>(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</li> <li>(ii) information that identifies in reasonably precise terms specific provider reimbursement rates contained in contracts between the health plan and a particular provider or formally affiliated provider group. Information that discloses trend, even specific trend, will <i>not</i> qualify for redaction. For example, if an insurer has a single pharmacy benefit manager (PBM), information about generic, brand and specialty drug costs per member will be disclosed. However, information about per unit dispensing fees paid to the PBM, or the level of rebates received, may be redacted.</li> </ol> </li> <li>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</li> </ol>	<p><a href="#">Supporting Documents - Redacted Documents for Web Posting</a></p>

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		<p>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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DATE

Group Number:

CONTACT NAME

GROUP NAME

ADDRESS 1

ADDRESS 2

CITY, ST ZIP

**Re: Proposed Rate Adjustments for 2014**

Dear Health Benefits Administrator:

We are writing to inform you that Independent Health will be applying to the New York State Department of Financial Services (DFS) for a rate change effective on your group's 2014 policy renewal date of [MONTH] 1, 2014. The premium amounts listed in the enclosed chart are for the plan you are offering as of June 30, 2013.

As you review the proposed rates, please note:

- Your group's final premium rates may be different if you change benefits or plans on or after July 1, 2013, or during the 2014 open enrollment period.
- Independent Health is in the process of finalizing benefit changes for 2014, as well as calculating the rate impact for government mandates that will be going into effect next year. As a result, these changes and mandates are not reflected in your group's proposed rates. However, the rates do include the applicable taxes and fees associated with the Affordable Care Act (i.e., the Health Insurance Tax, the Patient-Centered Outcomes Research Institute fee, user fees for operation of the federal risk adjustment program and fees to fund the federal reinsurance pool).
- If your group has locked into a fixed-rated premium that varies from the actual premium rate that is ultimately approved by the DFS, any settlement of this variance will be incorporated in the subsequent year renewal.
- The DFS may approve our proposed rate adjustments, modify the rates we submit, or disapprove the proposed premiums entirely.
- We will send you final confirmation of the approved premium rates for your current plan approximately 60 days before your group's 2014 renewal date.

**Rate Notification to your Employees**

In accordance with New York State law, notification to group subscribers is also required. As such, to assist our groups, we will send a similar proposed 2014 premium rate notification to our subscribers on or before July 10. We encourage you to share this information with others in your

organization who may get questions from your employees. We are also required to notify your employees of the approved premium rates for their current plan approximately 60 days before your group's 2014 renewal date.

### **Comment Period for Proposed Rates**

We intend to file our proposed rate adjustments with the DFS on July 10, 2013. If you would like to submit questions, comments or ask for additional information about the 2014 proposed rate request, you will have 30 days from the date we file our rate adjustment application to contact Independent Health or the DFS. Comments to the DFS may be made at the following web address: <https://myportal.dfs.ny.gov/web/prior-approval/welcome>. All comments submitted to the DFS will be posted to the department's website, with personal identifying information removed. Employers and subscribers should include Independent Health Association, large group, and product name in their written comments.

Independent Health Servicing Department

Attn: Proposed Rates

Independent Health

511 Farber Lakes Drive

Buffalo, NY 14221

E-mail address:

[premiumrates@independenthealth.com](mailto:premiumrates@independenthealth.com)

Phone Number: (716) 631-8072 or 1-800-755-5802

Health Bureau-Premium Rate Adjustments

New York State Department of Financial Services

One State Street, 2<sup>nd</sup> Floor

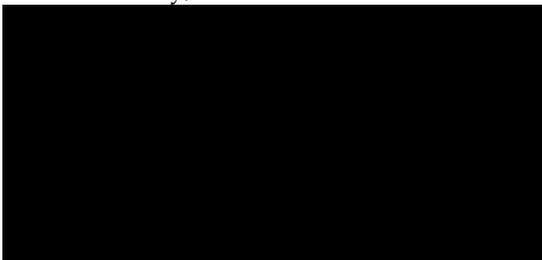
New York, NY 10004-1511

E-mail address: [PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov)

It is necessary for Independent Health to adjust rates for a number of reasons, such as aging population of the region, which contributes to the increase in the use and amount of medical services needed, projected increases in hospital, physician and pharmacy utilization, based on past years' trends, and increases in reimbursement fees to providers, including hospitals and physicians. We have prepared a narrative summary that provides a more detailed, plain English explanation of the reasons why we are seeking a premium rate adjustment. To review this narrative, go to [www.independenthealth.com](http://www.independenthealth.com) and click on the "2014 Proposed Rates" link in the "Useful Links" section, or visit the DFS website at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>.

We look forward to continuing to provide you and your employees with outstanding service and comprehensive benefits. If you have any questions or would like to learn more about other plans and services we offer that may meet your needs, please contact your Independent Health account manager or your broker.

Sincerely,



## Premium Rate Comparison

This chart includes your current group plan's 2013 monthly premium rates and the proposed 2014 monthly premium rates.

[GROUP NAME]

[PLAN NAME]

	2013 Monthly Premium	Proposed Monthly Premium on your 2014 Effective Date (pending DFS approval)
Single		
Employee and Spouse		
Family		
Employee and Child		

DATE

Subscriber Number:

SUBSCRIBER NAME

ADDRESS 1

ADDRESS 2

CITY, ST ZIP

**Re: Proposed Rate Adjustments for 2014**

Dear Subscriber:

New York State law requires health plans to submit proposed rate adjustments to the New York State Department of Financial Services (DFS) for review and approval. In accordance with these requirements, Independent Health will be submitting proposed rate adjustments to the DFS for an effective date of [MONTH] 1, 2014.

The premium amounts listed in the enclosed chart are for the health plan you are enrolled in as of June 30, 2013. As you review the proposed rates, please note:

- **These rates do not reflect any contribution that your employer may make toward your plan premium.**
- Your employer may decide to change your plan during the 2014 open enrollment period, which may cause your 2014 premium to be higher or lower than the proposed rates.
- Independent Health is in the process of finalizing benefit changes for 2014, as well as calculating the rate impact for government mandates that will be going into effect next year. As a result, these changes and mandates are not reflected in your group's proposed rates. However, the rates do include the applicable taxes and fees associated with the Affordable Care Act (i.e., the Health Insurance Tax, the Patient-Centered Outcomes Research Institute fee, user fees for operation of the federal risk adjustment program and fees to fund the federal reinsurance pool).
- The DFS may approve our proposed rate adjustment, modify the rate we submit, or disapprove the proposed premium entirely.
- Final confirmation of the approved premium rate for your current plan will be provided to you approximately 60 days before your group's 2014 renewal date.

**Comment Period for Proposed Rates**

We intend to file our proposed rate adjustments with the DFS on July 10, 2013. If you would like to submit questions, comments or ask for additional information about the 2014 proposed rate request, you will have 30 days from the date we file our rate adjustment application to contact Independent Health or the DFS. Comments to the DFS may be made at the following web address:

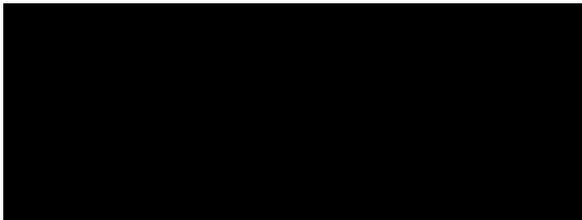
<https://myportal.dfs.ny.gov/web/prior-approval/welcome>. All comments submitted to the DFS will be posted to the department's website, with personal identifying information removed. Subscribers should include Independent Health Association, large group, and product name in their written comments.

Independent Health Servicing Department  
Attn: Proposed Rates  
Independent Health  
511 Farber Lakes Drive  
Buffalo, NY 14221  
E-mail address:  
[premiumrates@independenthealth.com](mailto:premiumrates@independenthealth.com)  
Phone Number: (716) 250-7116 or 1-888-503-1264

Health Bureau-Premium Rate Adjustments  
New York State Department of Financial Services  
One State Street, 2<sup>nd</sup> Floor  
New York, NY 10004-1511  
E-mail address: [PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov)

It is necessary for Independent Health to adjust rates for a number of reasons, such as aging population of the region, which contributes to the increase in the use and amount of medical services needed, projected increases in hospital, physician and pharmacy utilization, based on past years' trends, and increases in reimbursement fees to providers, including hospitals and physicians. We have prepared a narrative summary that provides a more detailed, plain English explanation of the reasons why we are seeking a premium rate adjustment. To review this narrative, go to [www.independenthealth.com](http://www.independenthealth.com) and click on the "2014 Proposed Rates" link in the "Useful Links" section, or visit the DFS website at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>.

Thank you for choosing Independent Health.



*Verbal translation, alternate formats of written materials, and/or assistance for those with special needs, may be available upon request. (Traducción verbal, formatos alternativos de materiales escritos y/o asistencia para quienes tienen necesidades especiales, disponibles a solicitud.)*

## Premium Rate Comparison

This chart compares your current plan's 2013 monthly premium rate and the proposed 2014 monthly premium rate. **These rates do not reflect any contribution that your employer may make toward your plan premium.**

[GROUP NAME]

[PLAN NAME]

	2013 Monthly Premium	Proposed Monthly Premium on your 2014 Effective Date (pending DFS approval)
Premium Rate		

DATE

Group Number:

CONTACT NAME

GROUP NAME

ADDRESS 1

ADDRESS 2

CITY, ST ZIP

**Re: Proposed Rate Adjustments for 2014**

Dear Health Benefits Administrator:

We are writing to inform you that Independent Health will be applying to the New York State Department of Financial Services (DFS) for a rate change effective on your group's 2014 policy renewal date of [MONTH] 1, 2014. The premium amounts listed in the enclosed chart are for the plan you are offering as of June 30, 2013.

As you review the proposed rates, please note:

- Your group's final premium rates may be different if you change benefits or plans on or after July 1, 2013, or during the 2014 open enrollment period.
- Independent Health is in the process of finalizing benefit changes for 2014, as well as calculating the rate impact for government mandates that will be going into effect next year. As a result, these changes and mandates are not reflected in your group's proposed rates. However, the rates do include the applicable taxes and fees associated with the Affordable Care Act (i.e., the Health Insurance Tax, the Patient-Centered Outcomes Research Institute fee, user fees for operation of the federal risk adjustment program and fees to fund the federal reinsurance pool).
- If your group has locked into a fixed-rated premium that varies from the actual premium rate that is ultimately approved by the DFS, any settlement of this variance will be incorporated in the subsequent year renewal.
- The DFS may approve our proposed rate adjustments, modify the rates we submit, or disapprove the proposed premiums entirely.
- We will send you final confirmation of the approved premium rates for your current plan approximately 60 days before your group's 2014 renewal date.

**Rate Notification to your Employees**

In accordance with New York State law, notification to group subscribers is also required. As such, to assist our groups, we will send a similar proposed 2014 premium rate notification to our subscribers on or before July 10. We encourage you to share this information with others in your

organization who may get questions from your employees. We are also required to notify your employees of the approved premium rates for their current plan approximately 60 days before your group's 2014 renewal date.

### **Comment Period for Proposed Rates**

We intend to file our proposed rate adjustments with the DFS on July 10, 2013. If you would like to submit questions, comments or ask for additional information about the 2014 proposed rate request, you will have 30 days from the date we file our rate adjustment application to contact Independent Health or the DFS. Comments to the DFS may be made at the following web address: <https://myportal.dfs.ny.gov/web/prior-approval/welcome>. All comments submitted to the DFS will be posted to the department's website, with personal identifying information removed. Employers and subscribers should include Independent Health Association, large group, and product name in their written comments.

Independent Health Servicing Department

Attn: Proposed Rates

Independent Health

511 Farber Lakes Drive

Buffalo, NY 14221

E-mail address:

[premiumrates@independenthealth.com](mailto:premiumrates@independenthealth.com)

Phone Number: (716) 631-8072 or 1-800-755-5802

Health Bureau-Premium Rate Adjustments

New York State Department of Financial Services

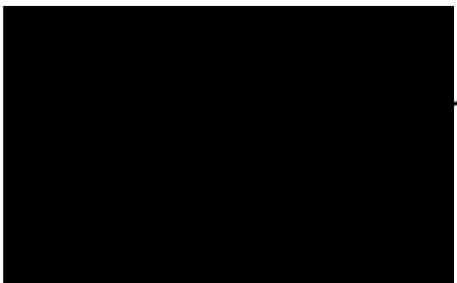
One State Street, 2<sup>nd</sup> Floor

New York, NY 10004-1511

E-mail address: [PremiumRateIncreases@dfs.ny.gov](mailto:PremiumRateIncreases@dfs.ny.gov)

It is necessary for Independent Health to adjust rates for a number of reasons, such as aging population of the region, which contributes to the increase in the use and amount of medical services needed, projected increases in hospital, physician and pharmacy utilization, based on past years' trends, and increases in reimbursement fees to providers, including hospitals and physicians. We have prepared a narrative summary that provides a more detailed, plain English explanation of the reasons why we are seeking a premium rate adjustment. To review this narrative, go to [www.independenthealth.com](http://www.independenthealth.com) and click on the "2014 Proposed Rates" link in the "Useful Links" section, or visit the DFS website at <https://myportal.dfs.ny.gov/web/prior-approval/welcome>.

We look forward to continuing to provide you and your employees with outstanding service and comprehensive benefits. If you have any questions or would like to learn more about other plans and services we offer that may meet your needs, please contact your Independent Health account manager or your broker.



## Premium Rate Comparison

This chart includes your current group plan's 2013 monthly premium rates and the proposed 2014 monthly premium rates.

[GROUP NAME]

[PLAN NAME]

	2013 Monthly Premium	Proposed Monthly Premium on your 2014 Effective Date (pending DFS approval)
Single		
Employee and Spouse		
Family		
Employee and Child		

DATE

Subscriber Number:

SUBSCRIBER NAME

ADDRESS 1

ADDRESS 2

CITY, ST ZIP

**Re: Proposed Rate Adjustments for 2014**

Dear Subscriber:

New York State law requires health plans to submit proposed rate adjustments to the New York State Department of Financial Services (DFS) for review and approval. In accordance with these requirements, Independent Health will be submitting proposed rate adjustments to the DFS for an effective date of [MONTH] 1, 2014.

The premium amounts listed in the enclosed chart are for the health plan you are enrolled in as of June 30, 2013. As you review the proposed rates, please note:

- **These rates do not reflect any contribution that your employer may make toward your plan premium.**
- Your employer may decide to change your plan during the 2014 open enrollment period, which may cause your 2014 premium to be higher or lower than the proposed rates.
- Independent Health is in the process of finalizing benefit changes for 2014, as well as calculating the rate impact for government mandates that will be going into effect next year. As a result, these changes and mandates are not reflected in your group's proposed rates. However, the rates do include the applicable taxes and fees associated with the Affordable Care Act (i.e., the Health Insurance Tax, the Patient-Centered Outcomes Research Institute fee, user fees for operation of the federal risk adjustment program and fees to fund the federal reinsurance pool).
- The DFS may approve our proposed rate adjustment, modify the rate we submit, or disapprove the proposed premium entirely.
- Final confirmation of the approved premium rate for your current plan will be provided to you approximately 60 days before your group's 2014 renewal date.

**Comment Period for Proposed Rates**

We intend to file our proposed rate adjustments with the DFS on July 10, 2013. If you would like to submit questions, comments or ask for additional information about the 2014 proposed rate request, you will have 30 days from the date we file our rate adjustment application to contact Independent Health or the DFS. Comments to the DFS may be made at the following web address:

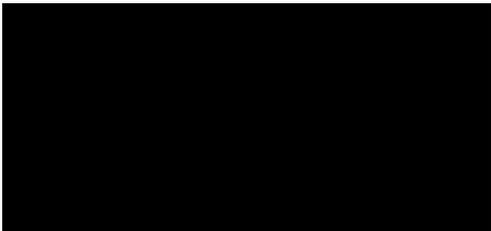
<https://myportal.dfs.ny.gov/web/prior-approval/welcome>. All comments submitted to the DFS will be posted to the department's website, with personal identifying information removed. Subscribers should include Independent Health Association, large group, and product name in their written comments.

Independent Health Servicing Department  
Attn: Proposed Rates  
Independent Health  
511 Farber Lakes Drive  
Buffalo, NY 14221  
E-mail address:  
[premiumrates@independenthealth.com](mailto:premiumrates@independenthealth.com)  
Phone Number: (716) 250-7116 or 1-888-503-1264

Health Bureau-Premium Rate Adjustments  
New York State Department of Financial Services  
One State Street, 2<sup>nd</sup> Floor  
New York, NY 10004-1511  
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Thank you for choosing Independent Health.



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## Premium Rate Comparison

This chart compares your current plan's 2013 monthly premium rate and the proposed 2014 monthly premium rate. **These rates do not reflect any contribution that your employer may make toward your plan premium.**

[GROUP NAME]

[PLAN NAME]

	2013 Monthly Premium	Proposed Monthly Premium on your 2014 Effective Date (pending DFS approval)
Premium Rate		



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# ACTUARIAL MEMORANDUM & CERTIFICATION

## RATE ADJUSTMENT FILING

### 2014 PREMIUM RATES

### LARGE GROUP COMMERCIAL PRODUCTS

For Independent Health Association

Prepared by:

[REDACTED]

Principal and Consulting Actuary

**Milliman Inc., New York**

One Pennsylvania Plaza  
38<sup>th</sup> Floor  
New York, NY 10119 USA

[REDACTED]

milliman.com

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## ATTACHMENT LISTING

Attachment A	Year Over Year Rate Increases by Base Policy Form
Attachment B	Quarter Over Quarter Rate Increases - All Base Plans and Riders
Attachment C	Rate Increase Analysis
Attachments D1-D4	Year Over Year Rate Increases - All Base Plans and Riders
Attachment E	2012 Source Data Trended to 2014
Attachment F	High-Level Rate Increase Calculation
Attachments G1-G3	Cost Model Development of Final 1 <sup>st</sup> Quarter Rates – Medical
Attachments H1-H2	Cost Model Comparison

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## INTRODUCTION

This Actuarial Memorandum and Certification supports Independent Health Association's (IHA's) 2014 Rate Adjustment Filing for its large group commercial products. IHA is an HMO under New York Law and this Rate Adjustment Filing is submitted pursuant to Section 4308(c) for the large group community rated products. This Actuarial Memorandum has been prepared in accordance with the New York State Department of Financial Services' (NYDFS') *Instructions/Review Standards for Rate Adjustment Filings Submitted Pursuant to Section 4308(c) of the New York Insurance Law* ("Checklist") as of 6/24/2013.

The Checklist is addressed chronologically in the Justification of Rates Section.

---

## ACTUARIAL QUALIFICATIONS

I, [REDACTED], am a consulting actuary with Milliman. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and I meet the Qualification Standards of Actuarial Opinion as adopted by the American Academy of Actuaries.

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## POLICY FORM LISTING

Pursuant to section 360.11(a)-(b) of Regulation 145 (11 NYCRR 360), policy forms presented in this memorandum are “substantially similar” and aggregated into one “Large Group” community pool for rating purposes. Table 1 below is a listing of each product included in this filing, and represents all of IHA’s large group products currently on file and approved by the NYDFS.

**TABLE 1  
LISTING OF FORM NUMBERS AND PRODUCTS**

<b>Form No.</b>	<b>Product Street Name</b>
<b>3270199</b>	Encompass A
<b>3850199</b>	Encompass B
<b>4570199</b>	Encompass C
<b>5170902</b>	Encompass D
<b>IHA-NYSHIP-C-001</b>	NYSHIP
<b>IHA-FEHB-C-001</b>	FEHB
<b>IHA-C1002</b>	Encompass HMO Plans
<b>IHA-C-101</b>	Encompass Essential
<b>IHA-C1000</b>	FlexFit (New)
<b>IHA-C1001</b>	FlexFit Select (New)

## SUMMARY OF POLICY FORM AND PRODUCT CHANGES

The following rate filings have been approved since the prior 4308 (c) filing.

**TABLE 2  
POLICY FORM AND PRODUCT CHANGES**

<b>Form No.</b>	<b>Product</b>	<b>Description of Benefit changes</b>
<b>IHA-C1002</b>	Encompass A-D, NYSHIP, FEHB	New HMO base product contract template
<b>IHA-E1001</b>	All IHA large group products	Preventive Endorsement – Women’s Wellness
<b>IHA-A1036</b>	All IHA large group products	Autism Mandate Amendment
<b>IHA-E-101</b>	All IHA large group products	Precertification Endorsement
<b>IHA-NYSHIP-C-001</b>	Encompass for NYSHIP	NYSHIP 2013 Benefit Changes
<b>IHA-A1038</b>	Encompass for FEHB	FEHBP HMO 2013 Benefit Changes

**IHA-C1002** – Effective April 1, 2012, IHA created a new HMO base plan contract. It was approved July 1, 2012. No members have enrolled in the base products associated with this form number. Therefore, the impact on the rate changes in Exhibits 4 and 5 is 0%.

**IHA-E1001** – Effective August 1, 2012, IHA amended the list of preventive services to comply with the Women’s Wellness Mandate included in the Patient Protection and Affordable Care Act. The amendment was approved August 24, 2012. The impact on 2013 rates was \$0.00 per member per month (PMPM). Therefore, the impact on the rate changes in Exhibits 4 and 5 is 0%.

**IHA-A1036** – Effective November 1, 2012, IHA amended the benefits for its base medical products to comply with the Autism Mandate. The amendment was approved September 10, 2012. The impact on 2013 rates was \$0.00 PMPM. Therefore, the impact on the rate changes in Exhibits 4 and 5 is 0%.

**IHA-E-101** – Effective November 1, 2012, IHA revised this endorsement to add applied behavior analysis and assistive communication devices to the list of services requiring precertification. There was no change to member benefits due to this revision. The impact on 2013 rates was \$0.00 PMPM. Therefore, the impact on the rate changes in Exhibits 4 and 5 is 0%.

**IHA-NYSHIP-C-001** – Effective January 1, 2013, IHA amended benefits for the Encompass for NYSHIP product. The 2013 estimated change to net claims costs due to this benefit change is a reduction of \$1.36 PMPM. This rate impact was reflected in the NYSHIP renewal rates on January 1, 2013, therefore the impact on the rate changes in Exhibits 4 and 5 is 0%.

**IHA-A1038** – Effective January 1, 2013, IHA amended benefits for the Encompass for FEHB product. The 2013 estimated change to net claims costs due to this benefit change is \$0.65 PMPM. This rate impact was reflected in the FEHB renewal rates on January 1, 2013, therefore the impact on the rate changes in Exhibits 4 and 5 is 0%.

## JUSTIFICATION OF RATES

This section chronologically addresses each of the required items in the NYDFS Checklist.

This filing reflects rate changes due to experience and claim trend only and does not reflect contract language changes as a result of the Patient Protection and Affordable Care Act (ACA) or otherwise. IHA is not filing a rate adjustment for any of its prescription drug riders.

### DESCRIPTION OF PROPOSED CHANGES IN RATES

- a.(i) Attachment A to this memorandum shows the proposed member-weighted average **year-over-year rate increases**, which are the rate changes over the current rates charged to each renewal cohort of policyholders for each base medical policy form. Rate increases shown include the impact of all associated riders available to each policy form. Rate changes for the prior 24 month period are also shown.
- a.(ii) Attachment B shows the average **quarter-over-quarter rate increases** for base medical and non-pharmacy rider policy forms including the change from the immediately preceding rolling rate table not included in this filing.

Table 3 below summarizes the minimum, maximum and average 1<sup>st</sup> quarter 2014 over 4<sup>th</sup> quarter 2013 rate change within each policy form (rate table).

**TABLE 3**  
**MINIMUM, MAXIMUM AND AVERAGE RATE CHANGES WITHIN A POLICY FORM**  
**1<sup>ST</sup> QUARTER 2014 OVER 4<sup>TH</sup> QUARTER 2013**

Form No.	Product Name	Minimum	Maximum	Average
3270199	Encompass A	-2.0%	-2.0%	-2.0%
3850199	Encompass B	-1.9%	-1.9%	-1.9%
4570199	Encompass C	-2.0%	-2.0%	-2.0%
5170902	Encompass D	-1.9%	-1.9%	-1.9%
IHA-NYSHIP-C-001	NYSHIP	-1.7%	-1.7%	-1.7%
IHA-FEHB-C-001	FEHB	-2.1%	-2.1%	-2.1%
IHA-C1002	Encompass	-2.1%	-1.7%	-1.9%
IHA-C-101	Encompass Essential	-1.8%	-1.4%	-1.7%
IHA-C1000	FlexFit (New)	-1.8%	-1.8%	-1.8%
IHA-C1001	FlexFit Select (New)	-1.7%	-1.7%	-1.7%

Please note that there is not a uniform transition from the 4th quarter of 2013 to the 1st quarter of 2014. This is because IHA files all four quarters of rates at once and consequently, fourth quarter rates are based on experience data centered 34½ months prior to the rate period. Thus, a significant time lapse exists between the experience period and the rate period, which increases the risk of inaccuracy of the rate calculation due to changing conditions.

- 
- a.(iii) Attachment B also shows the aggregate percentage change between successive rolling rate periods for the 24 month period prior to the effective date of the earliest rate table in this submission for base medical and non-pharmacy rider policy forms.
  - a.(iv) There is no rate impact due to **changes in pricing loss ratios**. Pricing loss ratio is 87%, consistent with 2013 rates.
  - a.(v) There is no rate impact due to **changes in Tier Factors**.
  - a.(vi) There is no rate impact due to **changes in the Conversion Factor**.
  - a.(vii) High-level estimates of rate **changes due to variances in claims costs** over prior periods are shown Attachment C. The box at the bottom of this Attachment segregates the rate increase into 3 components: (1) change due to trend from 2012 to 2014, (2) change due to the variance from prior period estimates, and (3) change due to other factors.
  - a.(viii) IHA has only **one rating region**, Western New York. Thus, there are no rating differentials between regions.

#### NEW BENEFIT OPTIONS

- b. There are **no new benefit options** being added to the existing rate table for which prior period rates have not already been approved.

#### PROPOSED RATE CHANGES – ALL BASE PLANS AND RIDERS

- c.(i) There are no non-rolling rate tables submitted in this filing.
- c.(ii) Attachments D1 through D4 present the current and proposed rates for each rating tier, along with the dollar and percentage change from the current rate to the proposed rate, for each benefit option for each policy form and rider form for the four 2014 quarters submitted in this filing.

#### DISCUSSION OF STANDARD PREMIUM DEVELOPMENT

- d. IHA calculates the Standardized Earned Premium at the group level, then sums to the policy form level.  
  
To calculate the standardized premium, the actual earned premium for each earned month for every combination of employer group and product is reduced back to a January level by removing the impact of the quarterly rolling rate trend, where applicable. This January premium is then adjusted to 2013 by applying the product rate changes implemented from the premium year to January 2013. The premium is then converted to a 4th quarter 2013 rate by applying the three 2013 quarterly rolling rate trends.

#### DESCRIPTION OF SOURCE DATA

- e.(i) The Source Data used for pricing is based on IHA's 2010 through 2012 large group claims experience based on claims paid through March 2013; thus, the unpaid claims liability in the Source Data is based upon 3 months of run-out.

- e.(ii) The Source Data is based entirely on IHA experience data.
- e.(iii) The intent of the credibility adjustment in the Federal Minimum Loss Ratio (MLR) rebate calculation is to address the impact of claims variability on the experience of small carriers. As discussed in the Federal Register<sup>1</sup>, the credibility adjustments were designed to “result in an issuer that charges premiums intended to produce an 80 percent MLR to pay a rebate less than 25 percent of the time.” For this calculation, the lower threshold is 1,000 life years (correlating to an 8.3% increase to the experience loss ratio for the rebate calculation) and the upper threshold is 75,000 life years (no adjustment to the experience loss ratio to determine the rebate).

For IHA’s large group products, the life years underlying the Source Data are shown by year and in total in Table 4 below.

**TABLE 4  
LIFE YEARS UNDERLYING  
MEDICAL SOURCE DATA**

<b>Year</b>	<b>Life Years</b>
<b>2010</b>	53,921
<b>2011</b>	55,965
<b>2012</b>	52,835
<b>TOTAL</b>	162,721

Based on these life years and the instructions provided in the Federal Register (interpolating), IHA’s Source Data is fully credible.

- e.(iv) The Source Data is projected to the rating period using separate average charge and utilization trend assumptions for each of 60 benefit categories. Specifically, the 2012 data is projected to calendar year 2014 using trends derived from 2010, 2011 and 2012 utilization experience as well as contracted unit charge changes for 2013 and 2014.

Attachment E shows how the 2012 Source Data is trended to 2014.

**TREND ASSUMPTIONS**

IHA developed the average charge and utilization trends for each of 60 types of service categories, and we reviewed them for reasonableness. Utilization trend assumptions were generally estimated using the least-squares-based “FORECAST” Excel function and the prior three years’ utilization experience; some manual overrides were employed where FORECAST results appeared to be unreasonable – due to low credibility of the type of service category. Average charge trends were developed based on anticipated (or contracted) provider fee increases.

- f.(i) The resulting average trend assumptions rolled up to the broad type of service category are summarized in Table 5 below. Please note that these are first dollar or “allowed” trends. Resulting claims cost trends are roughly 0.5% higher due to copay leveraging.

<sup>1</sup> Federal Register Vol 75, No. 230 Pg 74881

**TABLE 5  
IHA COMMERCIAL ALLOWED TREND ASSUMPTIONS 2012 TO 2014 (ANNUALIZED)  
BY BROAD TYPE OF SERVICE CATEGORY  
BASE MEDICAL PLANS AND NON-RX RIDERS  
LARGE GROUP**

SERVICE CATEGORY	UTILIZATION	ALLOWED CHARGE	PMPM
Hospital Inpatient	0.8%	9.0%	9.9%
Hospital Outpatient	2.8%	4.8%	7.8%
Physician	1.5%	3.2%	4.8%
Other	3.2%	0.4%	3.6%
Other Medical Expenses*			4.0%
<b>Total Trend</b>			<b>6.6%</b>

\* "Other Medical Expenses" includes BD&C taxes, GME, Large Group 146 surcharges, provider incentives, medical management savings initiatives, and other items related to managing the medical expense trend.

- f.(ii) Since trends are at the type of service category level, no explicit adjustment has been made for adverse selection or deductible leveraging. Table 8 shows the case mix/intensity component of the average charge trends presented in Table 7 above.

**TABLE 6  
SUMMARY OF CASE/MIX INTENSITY COMPONENT  
OFAVERAGE CHARGE TREND**

Type of Service Category	Case Mix / Intensity Adjustment
Inpatient Hospital	1.00%
Physician	0.50%

- f.(iii) Annualized trend factors were applied to the Source Data at the type of service category rather than at the product level. All products begin with the same aggregated projected 2014 data. Attachment E shows how trends were applied to the Source Data.

#### ACTUARIAL JUSTIFICATION OF PROPOSED RATE CHANGES

Attachment F shows our development of the "High-Level" rate increases. We describe the mechanics of this attachment below:

- **Column A** shows the 2012 member months, after transitions, which we use as weights.

- **Columns B, C and D** show the 2012 adjusted premium, estimated incurred claims, and resulting medical loss ratio for all base plans and riders.
- **Column E** shows the average target loss ratio for 2014.
- **Column F** shows the expected annualized trend from 2012 to 2014. These trend assumptions reflect “paid” trends rather than “allowed” trends since we are dealing with net claims costs rather than first dollar costs. Thus, trends shown are the final trend rates from Table 7 above, plus an additional 0.5% to account for copay leveraging.
- **Column G** is the average actual rate increase from 2012 to 2013.
- **Column H** is the high-level rate increase calculated as follows:

*High Level Rate Increase =*

$$\frac{\text{Loss Ratio}_{2012}}{\text{Target Loss Ratio}_{2014}} \times \frac{\text{Expected Trend}^2}{\text{Rate Incr}_{2013 \text{ over } 2012}}$$

- **Column I** shows the final average rate increase, calculated as a weighted average of the 2014 rates for each plan. The actual 2014 rate for each plan is derived from an actuarial cost model populated with IHA’s 2014 projected experience as shown in Attachment E. These models make provision, by type of service category, for benefit characteristics such as copays, deductibles, coinsurance and out-of-pocket maximum. For each type of service category, utilization is adjusted to reflect the anticipated change in utilization due to the average expected copay.

Note that all premium in Column B used to calculate the 2012 loss ratio has been adjusted to reflect 1st quarter 2012 premium levels. It does not reflect a mix of premium rate tables. The incurred claims in Column C used to calculate the 2012 loss ratio are based on 2012 claims paid through March 31, 2013 plus IBNR. The IBNR used is “best estimate” and does not contain margin for adverse deviation.

- g.(i) Attachments G1 through G3 show the premium rate development for one benefit option within each of the base medical policy forms. These attachments show how the projected Source Data (Attachment E) and expected loss ratio become incorporated into the proposed rate tables.
- Columns 1, 2, and 3 are the starting utilization, average allowed charges and resulting PMPMs taken from Attachment E. At the bottom of Column 3, we have two adjustments required to reconcile to Attachment E:
    - (1) non-claims medical expenses are adjusted to reflect the difference in these expenses for the particular product versus the average for all products, and
    - (2) the addition of dental expenses which appear in IHA’s Source Data, but is covered solely through a rider.
  - Column 4 is the Data Adjustment Factor. This represents the adjustment necessary to adjust the experience data because (1) it includes the impact of riders, and (2) it does not align exactly with IHA’s conversion and tier factors. The Data Adjustment Factor also adjusts for benefit differences between the benefit option and the average benefits underlying the Source Data.
  - Column 5 shows the percentage estimate of utilization associated with in-network only services.
  - Column 6 presents the final utilization for the benefit option, equal to the product of Columns 1, 4, and 5.
  - Column 7 shows the re-weighted final average charges based on the revised utilization.
  - Column 8 is the final gross cost PMPM, equal to Column 6 x Column 7 ÷ 12,000.
  - Column 9 shows the copay utilization for each service category
  - Column 10 shows the effective copay for each service category

- 
- Column 11 shows the PMPM value of the benefit option cost sharing
  - Column 12 shows the net claims cost PMPM = Column 8 – Column 11.

Below Column 12 we show a small incremental amount for the additional cost of services expected Out of Network along with the Value of Additional Benefits. The Additional Benefits represents the expected cost of the Women's Wellness and Autism Mandates which were not covered during the underlying experience period and the expected cost of the true additional benefits for FlexFit and FlexFit Select. We show the total net claims cost for the benefit option and the single premium as presented in the Attachment Ds filed with the Actuarial Memorandum.

- g.(ii) Development of the rolling rates for subsequent quarters for base rates and non-pharmacy riders is shown in the Attachment Ds. We developed the quarterly trends by dividing the "paid" annualized trends by four and rounding to the nearest one-quarter percent.
- g.(iii) No adjustment was made for the Standard Direct Pay and Healthy New York stop loss pools (New York Insurance Law Sections 4321-a, 4322-a, and 4327) since they are not applicable to these products.
- g.(iv) No adjustment was made for the NYS Market Stabilization pool, since this does not apply to large groups.
- g.(v) Independent Health utilizes its wholly-owned subsidiary to self-fund its exposure to large claims annually. Independent Health is charged a pooled premium based upon actual experience in its Article 44 individual, large group, and small group pools combined. However, for premium rate purposes the estimated recoveries to be applied against this premium are specific to each of the three pools noted above.

#### PERCENTAGE RATE CHANGE BY BENEFIT OPTION WITHIN A POLICY FORM

- h. The percentage rate change by benefit option within a policy form differs solely due to differences in benefits. Differences in rate changes are not due to insured population selection of available benefit options, nor are they due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. To demonstrate, please compare the starting values (Columns 1 through 3) in Attachment H1 to those in Attachment H2. Attachments H1 and H2 show the rate development for Encompass Essential Base 1 and Encompass Essential Base 2, respectively. Note that the only difference in benefit design is the copays. Columns 1 through 3 are identical between the options; the remaining columns adjust experience for benefit differentials between the current plan option and the average plan option inherent in the Source Data.

#### PERCENTAGE RATE CHANGE BY POLICY FORM WITHIN A COMMUNITY POOL

- i. Attachment A shows that the percentage rate change by policy form differs slightly within the large group community pool. This is due solely to benefit differential. Differences in rate changes are not due to insured population selection of available benefit options, nor are they due to differences in the age, sex, health status, or industry distributions of the members selecting a particular benefit option. To demonstrate, please compare the starting values (Columns 1 through 3) in each of the Attachments G1 through G3. Columns 1 through 3 are identical for each product. Remaining columns adjust experience for benefit differentials between the current plan option and the average plan option inherent in the Source Data.

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## PERCENTAGE RATE CHANGE BY RATING REGION

j. IHA has only one rating region, Western New York.

## DETAIL OF ADMINISTRATIVE LOAD

k. An allocation of our administrative expenses is attached in the required "Standard Exhibit 2". Please note that for 2014 IHA is incorporating additional taxes and fees due to the passage of the ACA. The following taxes and fees have been incorporated in the premium rates:

• Contributions to the Federal Transitional Reinsurance Program	\$5.25 PMPM
• PCORI Fee	\$2.00 PMPY
• Health Insurance Provider Fee	1.05% <sup>1</sup>
• New York State Exchange User Fee	0.0% <sup>1</sup>

<sup>1</sup> Percent of premium

IHA and Independent Health Benefits Corporation have undertaken a conversion to a new information system and claims platform. This effort commenced in early 2011, is expected to continue through 2014, and will result in a significant increase in the overall administrative expenses during this period. Independent Health has also commenced work on the conversion to ICD-10, which is expected to be implemented in the 4<sup>th</sup> quarter of 2014. Despite the added administrative burden, IHA has elected not to increase its filed retention on these products for 2014.

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## MINIMUM LOSS RATIOS

Under section 4308(c)(3)(A) of New York Insurance Law<sup>2</sup>, the expected minimum loss ratio for a large group contract form cannot be less than 82%. The target pricing loss ratios for IHA's base and non-prescription drug riders for each of the proposed four quarters in 2014 are presented below in Table 7. Note that rate increases between quarters are intended to reflect anticipated trend from quarter to quarter, thus preserving target loss ratios.

**TABLE 7**  
**2014 TARGET PRICING LOSS RATIOS**  
**BASE MEDICAL PLANS & RIDERS**

	New York Loss Ratio	Federal Loss Ratio
<b>1<sup>st</sup> Quarter</b>	85%	87%
<b>2<sup>nd</sup> Quarter</b>	85%	87%
<b>3<sup>rd</sup> Quarter</b>	85%	87%
<b>4<sup>th</sup> Quarter</b>	85%	87%

One minus the target loss ratio reflects the percent administrative load.

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<sup>2</sup> As amended by Chapter 107 of the laws of 2010.

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## DATA RELIANCE AND CAVEATS

The claims costs suggested were developed from assumptions that have been established based on the available data and other information provided by IHA. If more relevant data becomes available, the assumptions should be revised. A revision to these might change the results and possibly, the related conclusions. IHA should monitor emerging claims experience and adjust the rates as necessary. The rates provided are projections and actual experience will vary from projected. The rates should be frequently monitored for adequacy and adjusted as necessary.

This Actuarial Memorandum has been prepared by me on behalf of Independent Health Association and provided to insurance regulators in New York State for their internal use in accordance with established regulatory procedures. The accompanying Rate Adjustment Filing includes a redact version of this actuarial memorandum suitable for posting on the NYDFS website.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this memorandum. Any reader of this report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions used in the analysis, and the impact of the assumptions on the illustrated results.

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## ACTUARIAL CERTIFICATION

I, [REDACTED], Consulting Actuary, am a Member of the American Academy of Actuaries, and meet its qualification standards to provide this certification under 11NYCRR 52.40(a)(1) of New York Laws. I am associated with the firm of Milliman, Inc. My firm has been retained, and I have reviewed the attached premium rates for the 1st, 2nd, 3rd, and 4th quarters of 2014 for Independent Health Association's large group community pool containing the Encompass, Encompass Essential and FlexFit Select Large Group Products.

I have examined the premiums, reviewed the assumptions and methods used in their development, and did such tests and calculations of the premium rates as I considered necessary. I certify that:

- This filing is in compliance with all applicable laws and regulations of State of New York;
- The filing is in compliance with Actuarial Standard of Practice No. 8 "Regulatory Filings for Rates and Financial Projections for Health Plans";
- The expected loss ratios incorporated into the proposed rate tables meets the minimum requirements of the State of New York by permitted aggregation of policy forms within each permitted aggregation of rating regions:

MEDICAL BASE PLANS AND RIDERS	
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Large Group Pool	85%
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- The benefits are reasonable in relation to the premiums charged; and
- The rates are not unfairly discriminatory.

[REDACTED]

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[REDACTED], FSA, MAAA  
Principal & Consulting Actuary  
Milliman, Inc.  
July 12, 2012

**Attachment A**  
**Independent Health Association**  
**Summary of Proposed and Historical Rate Changes - Year Over Year**  
**2014 (Proposed), 2013 and 2012 (Historical)**  
**Member Weighted by Product**  
**Base Rates and Riders**  
**Large Group**

FORM No.	Product Street Name	Historical Rolling Rates - 2012 Over 2011				Historical Rolling Rates - 2013 Over 2012				Proposed Rolling Rates - 2014 Over 2013			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
<b>HMO Products</b>													
3270199	Encompass A	9.9%	9.2%	8.5%	N/A	4.8%	4.2%	3.7%	N/A	2.5%	2.5%	2.4%	N/A
3850199	Encompass B	10.3%	9.7%	9.0%	8.3%	4.6%	4.1%	3.8%	3.1%	2.6%	2.5%	2.6%	2.6%
4570199	Encompass C	10.3%	9.4%	8.9%	8.1%	4.4%	4.1%	3.7%	3.2%	2.6%	2.5%	2.5%	2.5%
5170902	Encompass D	11.1%	N/A	9.0%	8.8%	4.5%	N/A	3.7%	3.4%	2.8%	N/A	2.5%	2.6%
IHA-NYSHIP-C-001	NYSHIP	8.4%	N/A	N/A	N/A	4.2%	N/A	N/A	N/A	2.8%	N/A	N/A	N/A
IHA-FEHB-C-001	FEHB	5.2%	N/A	N/A	N/A	5.1%	N/A	N/A	N/A	2.5%	N/A	N/A	N/A
IHA-C1002	Encompass A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1002	Encompass B	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1002	Encompass C	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1002	Encompass D	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1002	NYSHIP	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1002	FEHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
610103-44	FlexFit	N/A	N/A	9.0%	8.2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1000	FlexFit (New)	9.2%	8.4%	N/A	N/A	4.6%	4.2%	3.7%	N/A	2.7%	2.6%	2.6%	N/A
IHA-FFS-C-0101	FlexFit Select	N/A	N/A	9.1%	8.4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
IHA-C1001	FlexFit Select (New)	9.1%	8.4%	N/A	N/A	4.8%	4.5%	3.9%	3.3%	2.8%	2.8%	2.8%	2.7%
IHA-C-101	Encompass Essential	9.7%	9.1%	7.7%	8.1%	5.0%	4.9%	4.3%	3.8%	2.8%	2.6%	2.6%	2.6%

**Attachment B**  
**Independent Health Association, Inc.**  
**Summary of Proposed and Historical Rate Changes - Quarter Over Quarter**  
**2014 (Proposed), 2013 and 2012 (Historical)**  
**Large Group**

Policy Form	Product Name / Description	Historical Rolling Rates - 2012 Over 2011				Historical Rolling Rates - 2013 Over 2012				Proposed Rolling Rates - 2014 Over 2013			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
<b>Base Medical Plans:</b>													
3270199	Encompass A	2.13%	2.25%	2.25%	2.25%	-3.70%	1.75%	1.75%	1.75%	-2.0%	1.73%	1.73%	1.73%
3850199	Encompass B	2.73%	2.25%	2.25%	2.25%	-3.80%	1.75%	1.75%	1.75%	-1.9%	1.73%	1.73%	1.73%
IHA-NYSHIP-C-001	Encompass for NYSHIP	0.66%	2.25%	2.25%	2.25%	-3.60%	1.75%	1.75%	1.75%	-1.7%	1.73%	1.73%	1.73%
4570199	Encompass C	2.60%	2.25%	2.25%	2.25%	-3.86%	1.75%	1.75%	1.75%	-2.0%	1.73%	1.73%	1.73%
5170902	Encompass D	2.77%	2.25%	2.25%	2.25%	-3.79%	1.75%	1.75%	1.75%	-1.9%	1.72%	1.73%	1.73%
IHA-FEHB-C-001	Encompass for FEHB	-3.34%	2.25%	2.25%	2.25%	-3.32%	1.75%	1.75%	1.75%	-2.1%	1.72%	1.73%	1.73%
IHA-C1002	Encompass A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-2.0%	1.73%	1.73%	1.73%
IHA-C1002	Encompass B	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-1.9%	1.73%	1.73%	1.73%
IHA-C1002	Encompass for NYSHIP	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-1.7%	1.73%	1.73%	1.73%
IHA-C1002	Encompass C	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-2.0%	1.73%	1.73%	1.73%
IHA-C1002	Encompass D	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-1.8%	1.73%	1.73%	1.73%
IHA-C1002	Encompass for FEHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-2.1%	1.73%	1.73%	1.73%
610103-44	FlexFit	3.11%	2.25%	2.25%	2.25%	-3.71%	1.75%	1.75%	1.75%	N/A	N/A	N/A	N/A
IHA-FFS-C-001	FlexFit Select	3.40%	2.25%	2.25%	2.25%	-3.34%	1.75%	1.75%	1.75%	N/A	N/A	N/A	N/A
IHA-C-101	Encompass Essential (Base 1)	1.69%	2.25%	2.25%	2.25%	-2.87%	1.75%	1.75%	1.75%	-1.6%	1.73%	1.72%	1.73%
IHA-C-101	Encompass Essential (E)	2.22%	2.25%	2.25%	2.25%	-3.05%	1.75%	1.75%	1.75%	-1.8%	1.72%	1.73%	1.73%
IHA-C-101	Encompass Essential (E) - FEHB	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-1.8%	1.72%	1.73%	1.73%
IHA-C-101	Encompass Essential (Base 2)	1.50%	2.25%	2.25%	2.25%	-2.89%	1.75%	1.75%	1.75%	-1.4%	1.72%	1.72%	1.72%
IHA-C1000	FlexFit New	1.56%	2.25%	2.25%	2.25%	-3.51%	1.75%	1.75%	1.75%	-1.8%	1.73%	1.73%	1.73%
IHA-C1001	FlexFit Select New	1.38%	2.25%	2.25%	2.25%	-3.39%	1.75%	1.75%	1.75%	-1.7%	1.73%	1.73%	1.73%
IHA-POS-001	Built-In POS Amendment on Enc. A & B - 20% Coin	28.95%	2.30%	2.24%	2.20%	37.73%	1.73%	1.70%	1.99%	-3.6%	1.70%	1.99%	1.64%
IHA-POS-001	Built-In POS Amendment on Enc. C & D - 25% Coin	23.13%	2.49%	2.16%	2.37%	46.91%	1.75%	1.72%	1.69%	-3.5%	1.73%	1.70%	1.83%

**Attachment B**  
**Independent Health Association, Inc.**  
**Summary of Proposed and Historical Rate Changes - Quarter Over Quarter**  
**2014 (Proposed), 2013 and 2012 (Historical)**  
**Large Group**

Policy Form	Product Name / Description	Historical Rolling Rates - 2012 Over 2011				Historical Rolling Rates - 2013 Over 2012				Proposed Rolling Rates - 2014 Over 2013			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
<b>Non-Drug Riders:</b>													
5180198	Rider 112 - Domestic Partner	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	N/A
1280198	Rider 128 - \$15 Outpatient Surgical Copay on Enc. C	-14.45%	2.03%	2.65%	1.94%	-13.21%	2.10%	0.75%	2.10%	-2.05%	2.09%	0.74%	1.98%
1520200	Rider 152 - \$20 Office Visit Copay on Enc. C	-25.34%	2.24%	2.39%	2.14%	-8.19%	1.88%	1.62%	1.80%	-0.60%	1.80%	1.94%	1.50%
3900186	Rider 24 - Abortion Exclusion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	N/A
4040195	Rider 29 - Dental Rider	-3.81%	2.24%	2.26%	2.25%	-1.78%	1.76%	1.74%	1.77%	0.75%	1.74%	1.75%	1.76%
4260191	Rider 45 - Inpatient Substance Abuse - Contract Year Benefits w/ Enc, FF or FFS	-31.40%	2.54%	2.48%	2.42%	-2.44%	2.50%	0.66%	2.43%	-10.00%	1.73%	2.46%	0.86%
4260191	Rider 45 - Inpatient Substance Abuse - Contract Year Benefits w/ Essential	-34.30%	1.77%	2.61%	1.69%	-1.71%	1.74%	2.46%	0.86%	-8.06%	0.93%	2.50%	1.73%
4330194	Rider 52 - Sterilization Exclusion	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	N/A
4210189	Rider B - \$0 Inpatient Copay on Enc B	-12.55%	2.48%	1.93%	2.84%	1.81%	1.81%	1.28%	1.80%	N/A	N/A	N/A	N/A
4760194	Rider C - \$250 Inpatient Copay on Enc C	-9.48%	1.90%	2.34%	2.28%	1.76%	1.80%	2.18%	1.66%	N/A	N/A	N/A	N/A
4770194	Rider D - \$0 Inpatient Copay on Enc C	-11.42%	2.39%	2.10%	2.28%	1.79%	1.99%	1.50%	1.68%	N/A	N/A	N/A	N/A
4950994	Rider E - \$500 Inpatient Copay on Enc. B	-12.65%	1.81%	2.67%	2.60%	0.80%	2.09%	1.61%	1.65%	N/A	N/A	N/A	N/A
4770100	Rider J - \$100 Inpatient Copay on Enc C	-10.67%	2.09%	2.63%	1.99%	1.40%	1.67%	1.89%	1.85%	-3.92%	1.94%	1.60%	1.81%
1700102	Rider 170 - Premier Vision Rider	-15.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
1941003	Rider 194 - Unlimited Skilled Nursing Facility	227.27%	2.78%	0.00%	2.70%	-39.36%	0.00%	4.61%	0.00%	-28.71%	0.00%	0.00%	11.06%
1950103	Rider 195 - FlexFit High Option II Rider	-15.40%	2.25%	2.20%	2.37%	3.56%	1.85%	1.58%	1.77%	N/A	N/A	N/A	N/A
4761002	Rider K - \$250 Hosp. Inpatient Copay reduction on Enc D	-10.34%	1.92%	2.83%	1.83%	2.66%	1.80%	2.18%	1.66%	N/A	N/A	N/A	N/A
202	Rider 202 - \$0 Child Office Service Copay Rider - A only	-5.56%	2.52%	2.05%	2.41%	27.81%	1.86%	1.78%	1.48%	-7.29%	1.91%	1.54%	1.84%
202	Rider 202 - \$0 Child Office Service Copay Rider - B only	-18.97%	2.34%	2.61%	1.59%	29.45%	1.71%	1.89%	1.66%	0.91%	1.59%	2.04%	1.53%
202	Rider 202 - \$0 Child Office Service Copay Rider - C only	-12.01%	2.35%	2.30%	2.25%	9.24%	1.79%	1.79%	1.94%	1.70%	1.87%	1.64%	1.81%
202	Rider 202 - \$0 Child Office Service Copay Rider - D only	-11.37%	2.20%	2.35%	2.11%	-6.18%	1.80%	1.59%	1.93%	-0.79%	1.74%	1.88%	1.84%
209	Rider 209 - \$250 Inpatient Copay Rider - FF Select	-14.81%	2.17%	2.13%	2.68%	2.02%	1.68%	1.99%	1.64%	-3.53%	1.40%	2.23%	1.33%
211	Rider 211 - \$15 pcp / \$30 scp Copay Rider - C only	-36.97%	2.23%	2.37%	2.14%	-14.12%	1.85%	1.58%	1.77%	6.54%	1.81%	1.78%	1.75%
211	Rider 211 - \$20 pcp / \$35 scp Copay Rider - C only	-33.60%	2.22%	2.39%	2.23%	-4.99%	1.84%	1.83%	1.70%	1.98%	1.72%	1.72%	1.76%
211	Rider 211 - \$20 pcp / \$35 scp Copay Rider - D only	-41.67%	2.22%	2.41%	2.35%	-1.62%	1.66%	1.81%	1.59%	5.10%	1.92%	1.65%	1.84%
211	Rider 211 - \$25 pcp / \$40 scp Copay Rider - D only	-35.23%	2.16%	2.24%	2.31%	-1.66%	1.69%	1.67%	1.87%	1.61%	1.81%	1.66%	1.75%
212	Rider 212 - DME / P&A @ 20% Copay Rider	-5.60%	2.06%	2.27%	2.47%	20.46%	1.80%	1.59%	1.93%	N/A	N/A	N/A	N/A
4980102	Rider 498 - NYS Eligibility Rider (multiplier)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
1600101	Rider 160 - Unlimited Home Health Rider	35.14%	2.00%	3.92%	0.00%	13.12%	1.76%	0.00%	3.11%	-14.20%	3.65%	0.00%	2.03%
IHA-R-219	Rider 219 - Additional Benefits Rider w/ Ess. Base 1 & E	48.47%	2.25%	2.29%	2.24%	-20.35%	1.76%	1.63%	1.80%	-9.21%	1.85%	1.70%	1.79%
IHA-R-219	Rider 219 - Additional Benefits Rider w/ Ess. Base 2	41.09%	2.27%	2.22%	2.27%	-21.33%	1.77%	1.72%	1.80%	-10.02%	1.74%	1.83%	1.67%
IHA-R-220	Rider 220 - Family Benefit Rider w/ Base E only	-33.33%	2.07%	2.39%	2.34%	-0.53%	1.77%	1.74%	1.71%	-0.83%	1.69%	1.98%	1.63%
IHA-R-220	Rider 220 - Family Benefit Rider w/ Base 1 only	-32.46%	2.41%	1.99%	2.31%	1.21%	1.72%	1.69%	1.83%	-0.65%	1.64%	1.78%	1.88%
IHA-R-221	Rider 221 - POS Rider w/o Additional Benefits w/ Base 1, 2 & E	-53.36%	2.70%	2.63%	0.85%	132.31%	1.44%	2.18%	1.39%	-1.37%	1.39%	2.10%	1.70%
efi IHA-R-221	Rider 221 - POS Rider w/ Additional Benefits w/ Base 1, 2 & E	-49.38%	1.63%	2.40%	2.34%	124.40%	1.74%	1.67%	1.68%	-2.57%	1.64%	1.66%	1.58%
IHA-R-223	Rider 223 - Unlimited SNF Rider w/ Base 1, 2 & E	181.55%	2.11%	2.48%	2.22%	-35.57%	1.86%	1.78%	1.48%	-27.70%	1.65%	2.01%	1.53%
IHA-R-224	Rider 224 - PT/OT in an Outpatient Hospital Facility w/ Base 1, 2 & E	190.91%	2.23%	2.18%	2.14%	-56.04%	1.95%	2.69%	0.96%	-18.96%	1.18%	2.08%	1.14%
IHA-R-001	Rider R-001 - ER Copay increase \$100 w/ Enc A - D only	25.71%	2.27%	3.33%	1.08%	-3.14%	2.08%	1.14%	1.12%	N/A	N/A	N/A	N/A
IHA-R-005	Rider R-005 - PT/OT/ST increase visit limits to 30 from 20	17.50%	1.06%	3.16%	3.06%	-30.73%	1.51%	2.67%	1.45%	0.00%	2.66%	1.50%	1.08%
IHA-R-005	Rider R-005 - PT/OT/ST increase visit limits to 45 from 20	16.53%	2.13%	2.78%	2.03%	-30.46%	1.95%	2.69%	0.96%	-2.80%	1.89%	2.69%	0.94%
IHA-OPTPOS-001	LG Bundle #1 - Enc A (POS only)	28.95%	2.30%	2.24%	2.20%	37.70%	1.73%	1.70%	1.99%	-3.59%	1.70%	1.99%	1.64%
IHA-OPTPOS-001 / IHA-R-213 / 216	LG Bundle #2 - Enc A (POS, DME/P&A)	15.53%	2.39%	1.98%	2.29%	31.57%	1.59%	1.93%	1.77%	-0.75%	1.77%	1.86%	1.69%
IHA-OPTPOS-001	LG Bundle #1 - Enc B (POS only)	28.95%	2.30%	2.24%	2.20%	37.73%	1.73%	1.70%	1.99%	-3.59%	1.70%	1.99%	1.64%
IHA-OPTPOS-001 / IHA-R-213 / 216 / 4210189	LG Bundle #2 - Enc B (IP \$0, POS, DME/P&A)	5.30%	2.38%	2.20%	2.28%	23.16%	1.70%	1.78%	1.75%	-1.52%	1.74%	1.81%	1.69%
IHA-OPTPOS-001 / 4760194	LG Bundle #1 - Enc C (\$250 IP, POS)	8.37%	2.28%	2.23%	2.35%	30.82%	1.75%	1.86%	1.69%	-3.57%	1.73%	1.69%	1.79%
IHA-OPTPOS-001 / IHA-R-213 / 216 / 4770194 / 1280198	LG Bundle #2 - Enc C (IP \$0, POS, DME/P&A, OP)	-3.52%	2.25%	2.20%	2.33%	17.33%	1.70%	1.76%	1.73%	-1.99%	1.73%	1.71%	1.81%
IHA-OPTPOS-001 / 4761002	LG Bundle #1 - Enc D (\$250 IP, POS)	4.59%	2.28%	2.23%	2.35%	30.82%	1.77%	1.85%	1.69%	-3.57%	1.73%	1.69%	1.79%
IHA-OPTPOS-001 / IHA-R-213 / 216 / 4770194	LG Bundle #2 - Enc D (IP \$0, POS, DME/P&A)	-2.51%	2.25%	2.20%	2.25%	21.64%	1.81%	1.71%	1.82%	-2.03%	1.75%	1.72%	1.78%
IHA-R-213 / 216 / 1950103	Large Bundle - FlexFit (IP \$0, DME/P&A)	-14.18%	2.00%	2.45%	2.24%	6.43%	1.76%	1.85%	1.70%	-0.55%	1.84%	1.77%	1.75%
IHA-R-213 / 216 / 209	Large Bundle - FFSelect (IP \$250, DME/P&A)	-6.52%	2.11%	2.48%	2.22%	7.12%	1.85%	1.44%	1.79%	-0.17%	1.76%	1.73%	1.70%
IHA-OPTR-SA-001	Rider SA-001 - Inpatient Substance Abuse Rider - Calendar Year Benefits	-31.40%	2.54%	2.48%	2.42%	-2.44%	2.50%	0.66%	2.43%	-10.00%	1.73%	2.46%	0.86%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc A	-37.86%	1.99%	2.60%	1.90%	6.21%	1.73%	1.78%	1.63%	-13.85%	1.86%	1.97%	1.83%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc B	-37.86%	1.99%	2.60%	1.90%	6.21%	1.73%	1.78%	1.63%	-13.85%	1.86%	1.97%	1.83%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc C	-37.86%	1.99%	2.60%	1.90%	6.21%	1.73%	1.78%	1.63%	-13.85%	1.86%	1.97%	1.83%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc D	-37.86%	1.99%	2.60%	1.90%	6.21%	1.73%	1.78%	1.63%	-13.85%	1.86%	1.97%	1.83%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Flex Fit	-40.76%	2.13%	2.78%	2.03%	8.58%	1.89%	1.73%	1.21%	-12.20%	1.96%	2.02%	1.83%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Flex Fit Select	-40.43%	2.14%	1.40%	3.45%	7.37%	1.83%	1.89%	1.73%	-11.76%	1.97%	1.39%	1.86%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc Ess Base	-39.41%	1.63%	2.40%	2.34%	6.83%	2.11%	0.74%	2.25%	-10.92%	2.25%	0.79%	2.13%
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc Ess Base 2	-39.41%	1.63%	2.40%	2.34%	6.83%	2.11%	0.74%	2.16%	-10.92%	2.25%	0.79%	2.13%

**Attachment B**  
**Independent Health Association, Inc.**  
**Summary of Proposed and Historical Rate Changes - Quarter Over Quarter**  
**2014 (Proposed), 2013 and 2012 (Historical)**  
**Large Group**

Policy Form	Product Name / Description	Historical Rolling Rates - 2012 Over 2011				Historical Rolling Rates - 2013 Over 2012				Proposed Rolling Rates - 2014 Over 2013			
		1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
IHA-R1000	Federal MHP Opt-Out Rider for Unions Enc Ess E	-39.41%	1.63%	2.40%	2.34%	6.83%	2.11%	0.74%	2.16%	-10.92%	2.25%	0.79%	2.13%
IHA-R1006	Your Natural Options Rider	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	N/A	N/A	N/A	N/A
IHA-R1007	FitWorks with Incentive	N/A	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.04%	1.74%	1.71%	1.82%
IHA-R1008	FitWorks without Incentive	N/A	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.82%	2.25%	0.79%	2.13%
IHA-R1009	\$500 IP Copay for FlexFit	-8.14%	1.90%	2.48%	3.03%	2.36%	1.78%	1.63%	2.23%	-5.43%	1.78%	1.63%	2.23%
IHA-R1009	\$500 IP Copay for FlexFit Select	-8.76%	2.26%	2.21%	2.70%	1.05%	1.57%	2.53%	1.03%	-4.95%	1.58%	2.52%	1.02%
IHA-R1019 / IHA-R-221	Additional Benefit Rider w/ POS - FEHB Ess E Only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-4.83%	1.65%	1.83%	1.73%

**Attachment C**  
**Independent Health Association**  
**Rate Increase Analysis**  
**Large Group Community Pool**  
**All Base Plans and Riders Combined**

2012 Actual Medical Loss Ratio	78.9%	A
2014 Target Loss Ratio	87.0%	B
Annualized Trend 2012 to 2014 (Paid)	7.0%	C
Actual Rate Increase 2012 to 2013	3.1%	D
High Level Rate Increase	0.8%	$E = A / B \times (1 + C)^2 / (1 + D) - 1$
Actual Rate Increase 2013 to 2014	0.8%	F
Change Due to Trend	7.0%	$G = C$
Change Due to Variance from Prior Periods	-5.8%	$H = A / B \times (1 + C) / (1 + D) - 1$
Change Due to Other	0.0%	$I = [(1 + F) / (1 + G) / (1 + H)] - 1$

**Attachment E**  
**Independent Health Association**  
**Source Data 2012 to Projected Experience 2014**  
**Large Group**

	2012 Experience - Source Data			Trends (Annualized)			2014 Projected Experience		
	Util/1000	Allwd Chg After COB	ALW After COB PMPM	Utilization	Alw Charge Trend	Total Trend	Util/1000	Allwd Chg After COB	ALW After COB PMPM
<b>Inpatient</b>	438.8	\$2,191.44	\$80.14	0.8%	9.0%	9.9%	445.9	\$2,602.26	\$96.70
<b>Outpatient</b>	9,879.2	\$90.66	\$74.63	2.8%	4.8%	7.8%	10,450.0	\$99.61	\$86.75
<b>Professional</b>	16,036.7	\$90.30	\$120.68	1.5%	3.2%	4.8%	16,530.0	\$96.14	\$132.43
<b>Other</b>	682.8	\$183.58	\$10.45	3.2%	0.4%	3.6%	727.2	\$185.16	\$11.22
<b>Total Claims Expenses</b>			<u>\$285.89</u>			7.0%			<u>\$327.10</u>
<b>Other Medical Expenses</b>			38.95			4.0%			42.16
<b>Total Base Medical Expenses</b>			\$324.84			6.6%			\$369.26

**Attachment F**  
**Independent Health Association - Large Group**  
**Illustration of High-Level Rate Increase Calculation for 2014 Rates**  
**Medical - Base Plans and Riders**

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>G</b>	<b>H</b>	<b>I</b>
	<b>2012 Members Months (excludes Transfers)</b>	<b>2012 Adjusted Premium PMPM</b>	<b>2012 Net Claims PMPM</b>	<b>2012 Medical Loss Ratio</b>	<b>2014 Target Loss Ratio</b>	<b>Annualized Expected Medical Paid Trend</b>	<b>Actual Rate Incr 2012 to 2013</b>	<b>High Level Rate Increase<sup>1</sup></b>	<b>Actual Rate Increase<sup>2</sup> 2013 to 2014</b>
<b>Group Medical Plans Total Encompass Pool</b>	663,294	\$383.57	\$302.83	78.9%	87.0%	7.0%	3.1%	0.8%	0.8%

1. High Level Rate Increase  $H = D / E \times (1+F)^2 / (1+G) - 1$

2. Actual rate increase shown is based on member-premium weighted averages



**Attachment G2**  
**Reconciliation of IHA Gross Claims Cost Budget**  
**to Final Cost Model Starting Utilization and Average Charge**  
**Independent Health - FlexFit & FlexFit Select**  
**Estimated Net Claims Costs as of January 1, 2014**  
**Standard Demographics - Large Group Rates**

<b><u>Benefit Option</u></b>	<b><u>FlexFit</u></b>	<b><u>FlexFit Select</u></b>
	<b><u>PMPM</u></b>	<b><u>PMPM</u></b>
Active Lifestyles	\$342.33	\$328.84
Family	\$346.47	\$330.33
<b><u>Final NCC PMPM</u></b>	<b><u>\$344.40</u></b>	<b><u>\$329.59</u></b>
<b>Final Single Premium PMPM</b>	<b>\$502.79</b>	<b>\$481.47</b>

*Final Single Premium = NCC PMPM ÷ 87% + ACA Taxes and Fees x 1.24*

**Attachment G-2a**  
**Reconciliation of IHA Gross Claims Cost Budget**  
**to Final Cost Model Starting Utilization and Average Charge**  
**Independent Health - FlexFit - Active Lifestyles**  
**Estimated Medical Cost as of July 1, 2014**  
**Large Group Rates**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.973	0.980	425.2	\$2,601.25	\$92.17	79.1	\$648.61	\$4.27	\$87.90
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.972	0.980	9,952.2	\$98.36	\$81.58	913.9	\$73.90	\$5.63	\$75.95
Professional			\$132.39	0.952	0.980			\$123.32			\$12.78	\$110.54
Other			\$56.79	0.973	0.981			\$56.30			\$3.53	\$52.77
Total Medical Cost			\$372.66					\$353.37			\$26.21	\$327.16
		Difference in Non-Claims	(\$3.47)								Value of OON Claims	\$9.13
		Add Back in Dental (Rider)	\$0.06								Value of Additional Benefits	\$6.03
		Ties to Attachment E of Actuarial Memorandum	\$369.25									
											<b>Total Medical Cost After Deductible and Coinsurance</b>	\$342.33
											<b>Final Single Premium = PMPM + ACA Taxes and Fees x 1.24 =</b>	\$499.82

Attachment G-2b  
 Reconciliation of IHA Gross Claims Cost Budget  
 to Final Cost Model Starting Utilization and Average Charge  
 Independent Health - FlexFit - Family Focus  
 Estimated Medical Cost as of July 1, 2014  
 Large Group Rates

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.976	0.980	426.5	\$2,601.25	\$92.45	65.4	\$569.07	\$3.10	\$89.35
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.975	0.980	9,981.9	\$98.36	\$81.82	916.6	\$68.74	\$5.25	\$76.57
Professional			\$132.39	0.962	0.980			\$124.53			\$11.96	\$112.57
Other			\$56.79	0.976	0.981			\$56.33			\$3.54	\$52.80
Total Medical Cost			\$372.66					\$355.13			\$23.85	\$331.28
	Difference in Non-Claims		(\$3.47)								Value of OON Claims	\$9.16
	Add Back in Dental (Rider)		\$0.06								Value of Additional Benefits	\$6.03
Ties to Attachment E of Actuarial Memorandum			\$369.25									\$346.47
											<b>Total Medical Cost After Deductible and Coinsurance</b>	\$346.47
											<b>Final Single Premium = PMPM + ACA Taxes and Fees x 1.24 =</b>	\$505.78

Attachment G-2c  
 Reconciliation of IHA Gross Claims Cost Budget  
 to Final Cost Model Starting Utilization and Average Charge  
 Independent Health - FlexFit Select - Active Lifestyles  
 Estimated Medical Cost as of July 1, 2014  
 Large Group Rates

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.964	0.980	421.3	\$2,601.25	\$91.32	78.3	\$735.09	\$4.80	\$86.52
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.963	0.980	9,859.8	\$98.36	\$80.82	907.0	\$86.01	\$6.50	\$74.32
Professional			\$132.39	0.906	0.980			\$119.19			\$18.42	\$100.77
Other			\$56.79	0.964	0.981			\$56.20			\$3.63	\$52.57
Total Medical Cost			\$372.66					\$347.53			\$33.35	\$314.18
		Difference in Non-Claims	(\$3.47)								Value of OON Claims	\$8.62
		Add Back in Dental (Rider)	\$0.06								Value of Additional Benefits	\$6.03
		Ties to Attachment E of Actuarial Memorandum	\$369.25									
											<b>Total Medical Cost After Deductible and Coinsurance</b>	<b>\$328.84</b>
											<b>Final Single Premium = PMPM + ACA Taxes and Fees x 1.24 =</b>	<b>\$480.39</b>

Attachment G-2d  
 Reconciliation of IHA Gross Claims Cost Budget  
 to Final Cost Model Starting Utilization and Average Charge  
 Independent Health - FlexFit Select - Family Focus  
 Estimated Medical Cost as of July 1, 2014  
 Large Group Rates

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.965	0.980	421.9	\$2,601.25	\$91.46	64.7	\$569.07	\$3.07	\$88.39
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.964	0.980	9,875.6	\$98.36	\$80.95	908.4	\$86.01	\$6.51	\$74.44
Professional			\$132.39	0.906	0.980			\$119.10			\$18.86	\$100.25
Other			\$56.79	0.966	0.981			\$56.22			\$3.64	\$52.58
Total Medical Cost			\$372.66					\$347.73			\$32.08	\$315.66
	Difference in Non-Claims		(\$3.47)								Value of OON Claims	\$8.64
	Add Back in Dental (Rider)		\$0.06								Value of Additional Benefits	\$6.03
	Ties to Attachment E of Actuarial Memorandum		\$369.25									\$330.33
											<b>Total Medical Cost After Deductible and Coinsurance</b>	<b>\$330.33</b>
											<b>Final Single Premium = PMPM + 87% + ACA Taxes and Fees x 1.24 =</b>	<b>\$482.53</b>

**Attachment G-3**  
**Reconciliation of IHA Gross Claims Cost Budget**  
**to Final Cost Model Starting Utilization and Average Charge**  
**Independent Health - Encompass Essential Base 1**  
**Estimated Medical Cost as of July 1, 2014**  
**Large Group Rates**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.781	1.000	348.5	\$3,158.56	\$91.72	75.2	\$500.00	\$3.13	\$88.58
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.951	1.000	9,935.4	\$98.63	\$81.66	785.6	\$72.46	\$4.74	\$76.92
Professional			\$132.39	0.872	1.000			\$118.59			\$23.25	\$95.34
Other			\$56.82	0.254	1.000			\$51.38			\$0.75	\$50.64
Total Medical Cost			\$372.69					\$343.35			\$31.87	\$311.48
	Difference in Non-Claims		(\$3.50)								Value of OON Claims	\$0.00
	Add Back in Dental (Rider)		<u>\$0.06</u>								Value of Additional Benefits	<u>\$1.12</u>
Ties to Attachment E of Actuarial Memorandum			\$369.25									
											<b>Total Medical Cost After Deductible and Coinsurance</b>	<u>\$312.60</u>
											<b>Final Single Premium = PMPM + ACA Taxes and Fees x 1.24 =</b>	<u>\$456.99</u>

**Attachment H1**  
**Reconciliation of IHA Gross Claims Cost Budget**  
**to Final Cost Model Starting Utilization and Average Charge**  
**Independent Health - Encompass Essential Base 1**  
**Estimated Medical Cost as of July 1, 2014**  
**Large Group Rates**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.781	1.000	348.5	\$3,158.56	\$91.72	75.2	\$500.00	\$3.13	\$88.58
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.951	1.000	9,935.4	\$98.63	\$81.66	785.6	\$72.46	\$4.74	\$76.92
Professional			\$132.39	0.872	1.000			\$118.59			\$23.25	\$95.34
Other			\$56.82	0.254	1.000			\$51.38			\$0.75	\$50.64
Total Medical Cost			\$372.69					\$343.35			\$31.87	\$311.48
	Difference in Non-Claims		(\$3.50)								Value of OON Claims	\$0.00
	Add Back in Dental (Rider)		<u>\$0.06</u>								Value of Additional Benefits	<u>\$1.12</u>
Ties to Attachment E of Actuarial Memorandum			\$369.25									
											<b>Total Medical Cost After Deductible and Coinsurance</b>	<u>\$312.60</u>
											<b>Final Single Premium = PMPM + 87% + ACA Taxes and Fees x 1.24 =</b>	<u>\$456.99</u>

**Attachment H2**  
**Reconciliation of IHA Gross Claims Cost Budget**  
**to Final Cost Model Starting Utilization and Average Charge**  
**Independent Health - Encompass Essential Base 2**  
**Estimated Medical Cost as of July 1, 2014**  
**Large Group Rates**

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
<b>Benefit</b>	<b>Utilization Per 1,000</b>	<b>Allowed Average Charge</b>	<b>Allowed PMPM</b>	<b>Data Adjustment Factor</b>	<b>In-Network Utilization Factor</b>	<b>Final Utilization</b>	<b>Final Avg Charge</b>	<b>Final Allowed PMPM</b>	<b>Copay Utilization</b>	<b>Average Copay</b>	<b>Per Member Per Month Cost Sharing</b>	<b>Net Per Member Per Month Claim</b>
Inpatient Facility	446.0 Days	\$2,602.87	\$96.74	0.773	1.000	344.8	\$3,158.56	\$90.77	74.4	\$1,000.00	\$6.20	\$84.57
Outpatient Facility	10,450.0 Cases	\$99.61	\$86.74	0.941	1.000	9,832.4	\$98.63	\$80.82	778.6	\$96.01	\$6.23	\$74.59
Professional			\$132.39	0.844	1.000			\$115.63			\$26.38	\$89.25
Other			\$56.82	0.252	1.000			\$51.32			\$0.78	\$50.55
Total Medical Cost			\$372.69					\$338.54			\$39.59	\$298.95
		Difference in Non-Claims	(\$3.50)								Value of OON Claims	\$0.00
		Add Back in Dental (Rider)	\$0.06								Value of Additional Benefits	\$1.12
		Ties to Attachment E of Actuarial Memorandum	\$369.25									\$300.07
											<b>Total Medical Cost After Deductible and Coinsurance</b>	\$300.07
											<b>Final Single Premium = PMPM + 87% + ACA Taxes and Fees x 1.24 =</b>	\$438.94

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

A. Insurer Information:	Independent Health Association, Inc. <small>Company submitting the rate adjustment request</small>	HMO - 44 <small>Company Type</small>	Not-for-Profit <small>Org. Type</small>	95308 <small>Company NAIC Code</small>
	511 Farber Lakes Drive, Buffalo, NY 14221			
	<small>Company mailing address</small>			
B. Contact Person:	[REDACTED]	[REDACTED]	[REDACTED]	
	<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):	[REDACTED]	[REDACTED]	[REDACTED]	
	<small>Actuary name, title</small>	<small>Actuary phone number</small>	<small>Actuary Email address</small>	
	1/1/2013 - 2/28/2014 (Rolling 1st Qtr - Group Plans)	1/1/2013 (1st Qtr - Group)		
	4/1/2013 - 5/31/2014 (Rolling 2nd Qtr - Group Plans)	4/1/2013 (2nd Qtr - Group)		
	7/1/2013 - 8/31/2014 (Rolling 3rd Qtr - Group Plans)	7/1/2013 (3rd Qtr - Group)		
D. New Rate Information (See Note #1):	10/1/2013 - 11/30/2014 (Rolling 4th Qtr - Group Plans)	10/1/2013 (4th Qtr - Group)	NDPD-129108707	
	<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):	Large Group - Quarterly Rolling Rates			
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).	No			
2. Are there any rate filings submitted and not yet approved that if approved would affect the rate tables included in this rate filing?	No			
3. Have the initial notices already been sent to all policyholders and contract holders affected by this rate submission? Indicate what cohort of policyholders received the initial notice and the mailing date when the initial notice was sent. See note (3).	Yes. All required notices were mailed prior to this application's submission. Employer notices were mailed on 7/8/2013. Notices for Subscribers were mailed 7/9/2013 through 7/10/2013.			
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?	No, Exhibit 4 - A, Exhibit 4 - C, Exhibit 4 - D and Exhibit 5 - A are not applicable. The explanation of the reason has been provided in the Supporting Documentation Tab in SERFF.			
5. Did the company submit a "Prior Approval Prefiling" containing a draft of the initial notice and a draft of the narrative summary associated with this rate filing? Indicate Yes or No, and if Yes, please provide the SERFF number of the prefilling.	Yes, NDPD-129096605			

**Notes:**

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



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

Company Name  
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.
- Indicate the market segment (e.g., Large Group, Small Group, etc.).
- Enter a descriptive title for the rating pool.
- Use a separate rate filing for each rating pool.
- Append additional information to the end of the filing.
- B. The average claim trend is the average annual claim trend for the rating pool.
- C. Enter the required information for the rating pool.
- D. Enter the corresponding information for the rating pool.
- 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. XX	18. Period assumed - beginning date (MM/DD/YYYY)	19. Period assumed - ending date (MM/DD/YYYY)	20. Average annual claim trend assumed	21.1 Regulatory authority licenses and fees, including New York State 332 assessment	Administrative expenses for activities that improve health care quality as defined in the NAIC Supplemental Health	21.3 Commissions and broker fees - as a % of gross premium	21.4 Premium Taxes - as a % of gross premium	21.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as a % of gross premium	21.6 Other administrative expenses as a % of gross premium	21.7 Subtotal columns 21.1 through 21.6	22. After tax underwriting margin (profit/contribution to surplus) - as a % of gross premium	23. State income tax component - as a % of gross premium	23.1 State income tax rate assumed (eg 3%)	24. Federal income tax component - as a % of gross premium	24.1 Federal income tax rate assumed (eg 30%)	25. Reduction for assumed net investment income - as a % of gross premium (enter as a negative value)	26. Subtotal lines 21.7 + 22 + 23 + 24 + 25	27.1 Regulatory authority licenses and fees, including New York State 332 assessment - as \$mpm	Administrative expenses for activities that improve health care quality as defined in the NAIC Annual Statement Supplemental Health Care Exhibit - as \$mpm	27.3 Commissions and broker fees - as \$mpm	27.4 Premium Taxes - as \$mpm	27.5 Other state and federal taxes and assessments (other than income taxes and covered lives assessments) - as \$mpm	27.6 Other administrative expenses as \$mpm	27.7 Subtotal lines 27.1 through 27.6	28. After tax underwriting margin (profit/contribution to surplus) - as \$mpm	29. State income tax component - as \$mpm	30. Federal income tax component - as \$mpm	31. Reduction for assumed net investment income - as \$mpm (enter as a negative value)	32. Subtotal columns 27.7 through 31	
LG	Large Group	XX	01/01/13	12/31/13	7.00%	0.15%	2.25%	0.10%	0.00%	0.00%	10.50%	13.00%	-0.28%	0.00%	0.00%	-0.15%	34.00%	0.00%	12.57%	0.76	11.26	0.48	0.00	0.00	52.52	65.02	(1.42)	0.00	0.00	(0.73)	62.87	
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## NARRATIVE SUMMARY

**Company:** Independent Health Association Inc.  
**NAIC Code:** 95308  
**SERFF Tracking #:** NDPD-129096605

Independent Health Association (IHA) is requesting premium rate adjustments for its large group HMO products and all applicable riders. All products and riders within this rate filing are community rated. This means that all members holding the same coverage pay the same approved premium. The number of subscribers affected by the proposed premium adjustments is 23,829.

### Taxes and Fees:

The following ACA taxes and fees are included in the proposed 2014 premium rates:

- Contributions to the Federal Transitional Reinsurance Program \$5.25 PMPM<sup>1</sup>
- Patient Centered Outcomes Research Fee \$2.00 PMPY<sup>2</sup>
- Health Insurance Tax (Percent of Premium) 1.05%

### Large Group HMO:

The following is a summary of the proposed rate adjustments to be effective on your next anniversary date on or after January 1, 2014:

Product Type	Product Name	Low	High	Average
Large Group	Encompass A	3.1%	3.2%	3.2%
Large Group	Encompass B	3.2%	3.3%	3.3%
Large Group	Encompass C	3.2%	3.3%	3.3%
Large Group	Encompass D	3.3%	3.4%	3.3%
Large Group	FlexFit	3.4%	3.5%	3.5%
Large Group	FlexFit Select	3.5%	3.6%	3.6%
Large Group	Encompass Essential Base (Version 1)	3.6%	3.6%	3.6%
Large Group	Encompass Essential "E" (Version 2)	3.4%	3.5%	3.5%
Large Group	Encompass Essential "E" - FEHB	3.4%	3.5%	3.5%
Large Group	Encompass Essential Base 2 Plan	3.8%	3.8%	3.8%
Large Group	Encompass for NYSHIP	3.5%	3.5%	3.5%
Large Group	Encompass for FEHB	3.1%	3.2%	3.2%
	<b>TOTAL</b>			<b>3.4%</b>
Large Group	Pharmacy Riders	0.0%	0.0%	0.0%
Large Group	Base Riders	-24.2%	9.0%	2.0%

<sup>1</sup> Per Member Per Month

<sup>2</sup> Per Member Per Year

Quarterly Trend:

Base and Base Riders: 1.75% per quarter

The key trends driving the proposed rate adjustments by medical expense category are as follows:

**Projected 2014 Large Group Medical Expense Trends  
Base and Base Rider Trends**

<b>Medical Expense Category</b>	<b>Utilization</b>	<b>Allowed Charge</b>	<b>PMPM (Per Member Per Month)</b>
Hospital Inpatient	0.8%	9.0%	9.9%
Hospital Outpatient	2.8%	4.8%	7.8%
Physician	1.5%	3.2%	4.8%
Other*	3.2%	0.4%	3.6%
Other Medical Expenses**			4.0%
<b>Total Trend</b>			<b>6.6%</b>

\* "Other" includes services such as home health, durable medical equipment, ambulance, medical dental services, and prosthetics and appliances.

\*\* "Other Medical Expenses" includes BD&C taxes, GME, Large Group 146 surcharges, provider incentives, medical management savings initiatives, and other items related to managing the medical expense trend.

Utilization represents the units of medical services per member per year. As noted in the exhibit above, the number of services rendered per member in the large group HMO plans is projected to increase in 2014 consistent with prior year historical trends.

Allowed Charge represents the anticipated negotiated changes in reimbursement to our providers (hospital, physicians, and other medical providers). In general, these are our expected reimbursement increases. This charge amount includes a modest adjustment for the intensity increase of the services being provided (more complicated procedures).

The PMPM column is the projected change in medical expense incurred for each member per month.

87% of the premium dollar for the IHA large group base and base rider rates. The remaining 13% of premium is available to IHA to cover administrative expenses. Administrative expenses include (but are not limited to) customer service, processing and paying claims, care management programs focused on quality and community benefits.

IHA also generates income from invested funds. The size of the portfolio and income generated from it vary from year to year. For 2014, IHA will be utilizing 100% of its anticipated investment income to cover losses in government programs such as Medicaid.

These proposed rate adjustments will be submitted to the New York State Department of Financial Services on approximately July 10<sup>th</sup> 2013. Your employer group will be notified of the final approved premium adjustment at least 60 days prior to your effective date of renewal.

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

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

Independent Health Association, Inc.  
 Company submitting the rate adjustment request

95308  
 Company NAIC Code

NDPD-129108707  
 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#      NDPD-129108707

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
3270199	LG	Western NY	Encompass A	Encompass A	1/1/2014	Jan. - Mar. 2014	3.21%	3.21%	3.21%
3850199	LG	Western NY	Encompass B	Encompass B	1/1/2014	Jan. - Mar. 2014	3.29%	3.29%	3.29%
4570199	LG	Western NY	Encompass C	Encompass C	1/1/2014	Jan. - Mar. 2014	3.28%	3.28%	3.28%
5170902	LG	Western NY	Encompass D	Encompass D	1/1/2014	Jan. - Mar. 2014	3.35%	3.35%	3.35%
IHA-FEHB-C-001	LG	Western NY	Encompass for FEHB	Encompass for FEHB	1/1/2014	Jan. - Mar. 2014	3.17%	3.17%	3.17%
IHA-NYSHIP-C-001	LG	Western NY	Encompass for NYSHIP	Encompass for NYSHIP	1/1/2014	Jan. - Mar. 2014	3.55%	3.55%	3.55%
IHA-C1000	LG	Western NY	FlexFit	FlexFit	1/1/2014	Jan. - Mar. 2014	3.46%	3.46%	3.46%
IHA-C1001	LG	Western NY	FlexFit Select	FlexFit Select	1/1/2014	Jan. - Mar. 2014	3.58%	3.58%	3.58%
IHA-C-101	LG	Western NY	Encompass Essential	Encompass Essential	1/1/2014	Jan. - Mar. 2014	3.47%	3.85%	3.53%
IHA-C1002	LG	Western NY	Encompass	Encompass	1/1/2014	Jan. - Mar. 2014	3.17%	3.54%	N/A
3270199	LG	Western NY	Encompass A	Encompass A	4/1/2014	Apr. - Jun. 2014	3.18%	3.18%	3.18%
3850199	LG	Western NY	Encompass B	Encompass B	4/1/2014	Apr. - Jun. 2014	3.27%	3.27%	3.27%

Base Medical Plan Rolling Rate Products

SERFF# NDPD-12910870

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
4570199	LG	Western NY	Encompass C	Encompass C	4/1/2014	Apr. - Jun. 2014	3.26%	3.26%	3.26%
5170902	LG	Western NY	Encompass D	Encompass D	4/1/2014	Apr. - Jun. 2014	3.33%	3.33%	N/A
IHA-FEHB-C-001	LG	Western NY	Encompass for FEHB	Encompass for FEHB	4/1/2014	Apr. - Jun. 2014	3.14%	3.14%	N/A
IHA-NYSHIP-C-001	LG	Western NY	Encompass for NYSHIP	Encompass for NYSHIP	4/1/2014	Apr. - Jun. 2014	3.52%	3.52%	N/A
IHA-C1000	LG	Western NY	FlexFit	FlexFit	4/1/2014	Apr. - Jun. 2014	3.44%	3.44%	3.44%
IHA-C1001	LG	Western NY	FlexFit Select	FlexFit Select	4/1/2014	Apr. - Jun. 2014	3.55%	3.55%	3.55%
IHA-C-101	LG	Western NY	Encompass Essential	Encompass Essential	4/1/2014	Apr. - Jun. 2014	3.44%	3.82%	3.44%
IHA-C1002	LG	Western NY	Encompass	Encompass	4/1/2014	Apr. - Jun. 2014	3.14%	3.52%	N/A
3270199	LG	Western NY	Encompass A	Encompass A	7/1/2014	Jul. - Sep. 2014	3.16%	3.16%	3.16%
3850199	LG	Western NY	Encompass B	Encompass B	7/1/2014	Jul. - Sep. 2014	3.25%	3.25%	3.25%
4570199	LG	Western NY	Encompass C	Encompass C	7/1/2014	Jul. - Sep. 2014	3.23%	3.23%	3.23%
5170902	LG	Western NY	Encompass D	Encompass D	7/1/2014	Jul. - Sep. 2014	3.31%	3.31%	3.31%
IHA-FEHB-C-001	LG	Western NY	Encompass for FEHB	Encompass for FEHB	7/1/2014	Jul. - Sep. 2014	3.12%	3.12%	N/A
IHA-NYSHIP-C-001	LG	Western NY	Encompass for NYSHIP	Encompass for NYSHIP	7/1/2014	Jul. - Sep. 2014	3.50%	3.50%	N/A
IHA-C1000	LG	Western NY	FlexFit	FlexFit	7/1/2014	Jul. - Sep. 2014	3.41%	3.41%	3.41%
IHA-C1001	LG	Western NY	FlexFit Select	FlexFit Select	7/1/2014	Jul. - Sep. 2014	3.53%	3.53%	3.53%
IHA-C-101	LG	Western NY	Encompass Essential	Encompass Essential	7/1/2014	Jul. - Sep. 2014	3.42%	3.80%	3.42%
IHA-C1002	LG	Western NY	Encompass	Encompass	7/1/2014	Jul. - Sep. 2014	3.12%	3.50%	N/A
3270199	LG	Western NY	Encompass A	Encompass A	10/1/2014	Oct. - Dec. 2014	3.14%	3.14%	N/A
3850199	LG	Western NY	Encompass B	Encompass B	10/1/2014	Oct. - Dec. 2014	3.22%	3.22%	3.22%
4570199	LG	Western NY	Encompass C	Encompass C	10/1/2014	Oct. - Dec. 2014	3.21%	3.21%	3.21%
5170902	LG	Western NY	Encompass D	Encompass D	10/1/2014	Oct. - Dec. 2014	3.28%	3.28%	3.28%
IHA-FEHB-C-001	LG	Western NY	Encompass for FEHB	Encompass for FEHB	10/1/2014	Oct. - Dec. 2014	3.09%	3.09%	N/A
IHA-NYSHIP-C-001	LG	Western NY	Encompass for NYSHIP	Encompass for NYSHIP	10/1/2014	Oct. - Dec. 2014	3.48%	3.48%	N/A
IHA-C1000	LG	Western NY	FlexFit	FlexFit	10/1/2014	Oct. - Dec. 2014	3.39%	3.39%	N/A
IHA-C1001	LG	Western NY	FlexFit Select	FlexFit Select	10/1/2014	Oct. - Dec. 2014	3.51%	3.51%	3.51%
IHA-C-101	LG	Western NY	Encompass Essential	Encompass Essential	10/1/2014	Oct. - Dec. 2014	3.40%	3.77%	3.40%
IHA-C1002	LG	Western NY	Encompass	Encompass	10/1/2014	Oct. - Dec. 2014	3.10%	3.47%	N/A

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

Company Name Independent Health Association Inc.  
 NAIC Code 95308  
 SERFF Tracking # NDPD-129108707

- Instructions**
- 1) The percentage rate change reflects the impact of all riders that apply to the contracts. The percentage rate change reflects the expected change in premium that would apply to the contract holder on that contract holder's next rate change date.
  - 2) The effective date is the earliest date that the proposed new rate would become effective if approved. The effective period of a new rolling rate may vary depending on the rolling rate structure (e.g., Q1 2013 for a quarterly rolling rate structure)
  - 3) The distribution is by number of members or number of contracts. The Company should fill in the appropriate column below (members or contracts) and replace the mm/dd/yy placeholder with the applicable as of date.
  - 4) The Weighted Average Percentage should be developed based on the distribution of annualized premiums for that Market Segment/Rating Region/Product and for the market segment in total.
  - 5) Market segment refers to Individual ( ND), Small Group (SG), Sole Proprietor (SP), Large Group (LG), Individual Healthy NY (HNY- ND), Small Group Healthy NY (HNY-SG), Individual Medicare Supplement (MS-INS), and Group Medicare Supplement (MS-GRP). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
  - 6) Under each market segment, the table should provide the distribution by broad product type (e.g., HMO, POS, EPO, PPO, Indemnity, High Deductible/Consumer Driven, Medicare Supplement, etc.).
  - 7) Provide distribution information for each rolling rate cohort of a rolling rate structure contract affected by this rate submission (e.g., by quarter of renewal for a quarterly rolling rate structure).
  - 8) Edit the worksheet to add more rows as needed. Only use the first tab for data entry.
  - 9) After each effective period/market segment combination there should be a market segment total row. Enter Total in the "Product" column, the sum of the counts in the various columns, and the market segment weighted avg %.
  - 10) This exhibit must be submitted as an Excel file and a PDF file.

**FOR ROLLING RATE STRUCTURE PRODUCTS - Distribution of Rolling Rate Contracts by Proposed Rate Adjustment by Each Rolling Rate Cohort** SERFF# **NDPD-129108707**

Effective Date	Effective Period	Market Segment	Rating Region	Product	Weighted Avg %	Annualized Premiums as of 6/15/2013	Total # of Members as of	Total # of Contracts as of	Number of (*) with Proposed Percentage Rate Change at Renewal											
									Decrease	No Change	0.1% - 4.9%	5.0% - 9.9%	10.0% - 14.9%	15.0% - 19.9%	20.0% - 24.9%	25.0% - 29.9%	30.0% - 39.9%	40.0% - 49.9%	50.0% or higher	
1/1/2014	Jan. - Mar. 2014	LG	Western NY	HMO	2.7%	\$302,056,946.40	22,965	22,965	-	-	22,965	-	-	-	-	-	-	-	-	-
		<b>Market Segment Total</b>						22,965	-	-	22,965	-	-	-	-	-	-	-	-	-
4/1/2014	Apr. - Jun. 2014	LG	Western NY	HMO	2.6%	\$3,353,892.48	253	253	-	-	253	-	-	-	-	-	-	-	-	-
		<b>Market Segment Total</b>						253	-	-	253	-	-	-	-	-	-	-	-	-
7/1/2014	Jul. - Sep. 2014	LG	Western NY	HMO	2.6%	\$6,818,564.16	511	511	-	-	511	-	-	-	-	-	-	-	-	-
		<b>Market Segment Total</b>						511	-	-	511	-	-	-	-	-	-	-	-	-
10/1/2014	Oct. - Dec. 2014	LG	Western NY	HMO	2.6%	\$1,264,536.24	100	100	-	-	100	-	-	-	-	-	-	-	-	-
		<b>Market Segment Total</b>						100	-	-	100	-	-	-	-	-	-	-	-	-

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

**Company Name:** Independent Health Association

**NAIC Code:** 95308

**SERFF Number:** NDPD-129108707

**Instructions:**

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

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

Filing Status	SERFF #	NY State Tracking #	Date of Submission	Policy Form #	Product Name (including Street Name)	Brief Description of Benefit/Rate Change	Approval Date
Approved	NDPD-128728192	2012120093	12/19/2012	IHA-A1038	Group HMO Products	IHA (Art. 44) FEHB 2013 Changes	1/22/2013
Approved	NDPD-128701546	2012100102	12/5/2012	IHA-NYSHIP-C-001	Group HMO Products	NYSHIP 2013 Changes	12/5/2012
Approved	NDPD-128719096	2012100067	10/8/2012	IHA-E1001, IHA-A1036	All Products	IHA (Art. 44) 2013 Women's Wellness and Autism Mandates	10/22/2012
Approved	NDPD-128674162	2012100031	10/3/2012	IHA-E-101	All Products	IHA (Art. 44) Precertification Endorsement	10/10/2012
Approved	NDPD-128519246	2012060251	6/27/2012	IHA-E1001	All Products	IHA (Art. 44) Preventive Endorsement - Women's Wellness	8/24/2012
Approved	NDPD-128015631	2012030037	3/1/2012	IHA-C1002	Group HMO Products	IHA (Art. 44) Contract Template (Encompass A-D)	7/31/2012

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

Company Name: Independent Health Association  
 NAIC Code: 95308  
 SERFF Number: NDPD-129108707

- 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), and Group Medicare Supplement (MS-GRP). If the proposed percentage rate change for Sole Proprietor is different from Small Group, then a separate market segment of Sole Proprietor (SP) is to be reported; otherwise, use small group. Use the drop down list to enter the market segment.
- 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														NY statewide experience										
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	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 receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$)	
3270199, 3850199, 4570199, 5170902, IHA-NYSHIP-C-001, IHA-FEHB-C-001	Encompass	Encompass A, Encompass B, Encompass C, Encompass D, Encompass for NYSHIP, Encompass for FEHB	HMO LG	01/01/14	LG	HMO	Yes	No	Open	12	2.64%	11,598	45,236	87.4%	XX	01/01/12	12/31/12	591,369	290,444,280	321,390,261	230,513,542	231,990,492	0	0
610103-44	FlexFit	FlexFit	HMO LG	01/01/14	LG	HMO	Yes	No	Closed	12	0.00%	0	0	87.4%	XX	01/01/12	12/31/12	0	0	0	0	0	0	0
IHA-C1000	FlexFit	FlexFit	HMO LG	01/01/14	LG	HMO	Yes	No	Open	12	2.71%	18	3,015	87.4%	XX	01/01/12	12/31/12	40,210	19,726,178	21,882,158	14,425,735	14,510,901	0	0
IHA-FFS-C-001	FlexFit Select	FlexFit Select	HMO LG	01/01/14	LG	HMO	Yes	No	Closed	12	0.00%	0	0	87.4%	XX	01/01/12	12/31/12	0	0	0	0	0	0	0
IHA-C1001	FlexFit Select	FlexFit Select	HMO LG	01/01/14	LG	HMO	Yes	No	Open	12	2.80%	22	1,692	87.4%	XX	01/01/12	12/31/12	23,342	11,276,066	12,593,222	8,268,763	8,313,672	0	0
IHA-C-101	Encompass Essential	Encompass Essential	HMO LG	01/01/14	LG	HMO	Yes	No	Open	12	2.73%	34	1,263	87.4%	XX	01/01/12	12/31/12	14,199	6,919,733	7,767,740	4,081,292	4,107,166	0	0
			HMO LG	01/01/14	LG	HMO	Yes	No	Open	12	2.65%	11,672	51,206	87.4%	XX	01/01/12	12/31/12	669,120	328,366,257	363,633,382	257,289,332	258,922,232	0	0

EXHIBIT 7 HISTO

- A. Complete a separate R
  - Information request
  - Include riders that r
  - Insert additional row
  - Add a row with the
- B. In Column 2 enter a Ra
- C. Market segment refers  
If the proposed percent
- D. Product type is HMO, H  
Supplement (A, B, C, D
- E. The product street nam
- F. Note that many cells in
- G. If members, covered liv
- H. This form must be subn

Most Recent Experience Period (NY statewide experience, base medical policy form + associated riders)														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	14.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	14.11 Earned premiums for experience period (\$mpm)	14.12 Standardized premiums for experience period (\$mpm)	14.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from the Regulation 146 pool (\$mpm)	14.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from the Regulation 146 pool (\$mpm)	14.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	14.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter receipts as a negative value and payments to the pool as a positive value) (\$mpm)	14.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	14.18 Ratio: Col 14.7 / Col 14.4 (Incurred Claims / Earned Premiums)	14.19 Ratio: Col 14.7 / Col 14.5 (Incurred Claims / Standardized Earned Premiums)	14.20 Ratio: Col 14.4 (Administration Expenses / Earned Premiums)	14.21 Ratio: (Col 14.7 + Col 14.8) / Col 14.4	14.22 XX	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 receipts from or 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 receipts from or payments to the Regulation 146 pool (\$)	15.8 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$)	15.9 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool 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 receipts from or 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 receipts from or 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)
3270199, 3850199, 4570199, 5170902, IHA-NYSHIP-C-001, IHA-FEHB-C-001	Encompass	39,847,659	491.14	543.47	389.80	392.29	0.00	0.00	67.38	0.799	0.722	0.137	0.936	XX	01/01/11	12/31/11	630,916	280,490,347	333,770,257	230,934,468	230,934,468	0	0	39,441,263	444.58	529.02	366.03	366.03	0.00
610103-44	FlexFit	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX	01/01/11	12/31/11	13,027	5,897,691	6,972,690	5,015,074	5,015,074	0	0	811,598	452.73	535.25	384.98	384.98	0.00
IHA-C-1000	FlexFit	2,709,720	490.58	544.20	358.76	360.88	0.00	0.00	67.59	0.736	0.663	0.137	0.873	XX	01/01/11	12/31/11	44,988	20,485,075	24,656,866	16,531,619	16,531,619	0	0	2,816,257	454.90	548.08	367.47	367.47	0.00
IHA-FFS-C-001	FlexFit Select	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.000	0.000	0.000	0.000	XX	01/01/11	12/31/11	6,883	2,833,958	3,445,408	2,443,105	2,443,105	0	0	400,499	424.05	515.55	365.57	365.57	0.00
IHA-C1001	FlexFit Select	1,572,999	483.08	539.51	354.24	356.17	0.00	0.00	67.39	0.737	0.660	0.139	0.877	XX	01/01/11	12/31/11	20,660	9,264,985	11,122,948	7,061,275	7,061,275	0	0	1,309,342	448.45	538.38	341.78	341.78	0.00
IHA-C-101	Encompass Essential	956,240	487.34	547.06	287.44	289.26	0.00	0.00	67.35	0.594	0.529	0.138	0.732	XX	01/01/11	12/31/11	16,576	7,688,008	9,419,526	4,181,516	4,181,516	0	0	1,035,922	463.80	568.26	252.26	252.26	0.00
		45,086,618	490.74	543.45	384.52	386.96	0.00	0.00	67.38	0.789	0.712	0.137	0.926	XX	01/01/11	12/31/11	732,850	326,640,065	389,387,694	266,167,059	266,167,059	0	0	45,814,880	445.71	531.33	363.19	363.19	0.00

EXHIBIT 7 HISTO

- A. Complete a separate R
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If the proposed percent
- D. Product type is HMO, H  
Supplement (A, B, C, D
- E. The product street nam
- F. Note that many cells in
- G. If members, covered liv
- H. This form must be subn

		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	15.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter negative value and payments to the pool as a positive value) (\$mpm)	15.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	15.18 Ratio: Col 15.7/ Col 15.4 (Incurred Claims / Earned Premiums)	15.19 Ratio: Col 15.7/ Col 15.5 (Incurred Claims / Standardized Earned Premiums)	15.20 Ratio: Col 15.10/ Col 15.4 (Administrative Expenses / Earned Premiums)	15.21 Ratio: (Col 15.7 + Col 15.10) / Col 15.4	16.1 Beginning date of the experience period (MM/DD/YYYY)	16.2 Ending Date of the experience period (MM/DD/YYYY)	16.3 Member months for experience period	16.4 Earned premiums for experience period (\$)	16.5 Standardized earned premiums for experience period (\$)	16.6 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for payments to the Regulation 146 pool (\$)	16.7 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or 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 negative value and payments to the pool as a positive value) (\$)	16.10 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$)	16.11 Earned premiums for experience period (\$mpm)	16.12 Standardized premiums for experience period (\$mpm)	16.13 Paid claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	16.14 Incurred claims for experience period - before any adjustment for amounts received from the standard direct pay and Healthy NY stop loss pools and before any adjustment for receipts from or payments to the Regulation 146 pool (\$mpm)	16.15 Adjustment to the incurred claims for the period due to receipts from the standard direct pay or Healthy NY stop loss pools (enter receipts from the pool as a negative value) (\$mpm)	16.16 Adjustment to the incurred claims for the period due to receipts from or payments to the Regulation 146 pool (enter negative value and payments to the pool as a positive value) (\$mpm)	16.17 Administrative expenses for experience period (including commissions and premium taxes, but excluding federal and state income taxes) (\$mpm)	16.18 Ratio: Col 16.7/ Col 16.4 (Incurred Claims / Earned Premiums)	16.19 Ratio: Col 16.7/ Col 16.5 (Incurred Claims / Standardized Earned Premiums)	16.20 Ratio: Col 16.10/ Col 16.4 (Administrative Expenses / Earned Premiums)	16.21 Ratio: (Col 16.7 + Col 16.9) / Col 16.4		
3270199, 3850199, 4570199, 5170902, IHA-NYSHIP-C-001, IHA-FEHB-C-001	Encompass	0.00	62.51	0.823	0.692	0.141	0.964	XX	01/01/10	12/31/10	594,577	261,586,245	340,956,250	217,570,324	217,570,324	0	0	31,171,616	439.95	573.44	365.92	365.92	0.00	0.00	52.43	0.832	0.638	0.119	0.951	
610103-44	FlexFit	0.00	62.30	0.850	0.719	0.138	0.988	XX	01/01/10	12/31/10	69,254	27,893,117	35,078,480	23,406,641	23,406,641	0	0	3,323,739	402.77	506.52	337.98	337.98	0.00	0.00	47.99	0.839	0.657	0.119	0.958	
IHA-C1000	FlexFit	0.00	62.60	0.808	0.670	0.138	0.945	XX	01/01/10	12/31/10	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
IHA-FFS-C-001	FlexFit Select	0.00	59.93	0.862	0.709	0.141	1.003	XX	01/01/10	12/31/10	45,767	17,992,826	23,057,483	18,166,745	18,166,745	0	0	2,144,022	393.14	503.80	396.94	396.94	0.00	0.00	46.85	1.010	0.788	0.119	1.129	
IHA-C1001	FlexFit Select	0.00	63.38	0.782	0.635	0.141	0.903	XX	01/01/10	12/31/10	0	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
IHA-C-101	Encompass Essential	0.00	62.50	0.544	0.444	0.135	0.679	XX	01/01/10	12/31/10	18,332	7,460,433	10,069,623	4,836,809	4,836,809	0	0	888,984	406.96	549.29	263.85	263.85	0.00	0.00	48.49	0.648	0.480	0.119	0.767	
		0.00	62.52	0.815	0.684	0.140	0.955	XX	01/01/10	12/31/10	727,930	314,932,621	409,161,837	263,980,519	263,980,519	0	0	37,528,362	432.64	562.09	362.65	362.65	0.00	0.00	51.55	0.838	0.645	0.119	0.957	

EXHIBIT 7 HISTO

- A. Complete a separate R
  - Information request
  - Include riders that r
  - Insert additional row
  - Add a row with the
- B. In Column 2 enter a Ra
- C. Market segment refers  
If the proposed percent
- D. Product type is HMO, H  
Supplement (A, B, C, D
- E. The product street nam
- F. Note that many cells in
- G. If members, covered liv
- H. This form must be subn

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/intens ity/other	18.1 Member months	18.2 Earned premiums (\$mpm)	18.3 Standardi zed 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 Administr ative expenses (including commissi ons and premium taxes, but excluding federal and state income taxes) (\$mpm)	19.1 Member months	19.2 Earned premiums (\$mpm)	19.3 Standardi zed 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 Administr ative expenses (including commissi ons and premium taxes, but excluding federal and state income taxes) (\$mpm)	20.1 Most Recent Experience Period	20.2 First Prior Experience Period	20.3 Second Prior Experience Period				
3270199, 3850199, 4570199, 5170902, IHA-NYSHIP-C-001, IHA-FEHB-C-001	Encompass	XX	7.12%	2.04%	4.48%	0.48%	XX	0.937	1.105	1.027	1.065	1.072	1.078	XX	1.061	1.011	0.923	1.000	1.000	1.192	XX	1.107	1.190	1.303
610103-44	FlexFit	XX	7.12%	2.04%	4.48%	0.48%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.188	1.124	1.057	1.139	1.139	1.298	XX	0.000	1.182	1.258
IHA-C1000	FlexFit	XX	7.12%	2.04%	4.48%	0.48%	XX	0.894	1.078	0.993	0.976	0.982	1.077	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.109	1.205	0.000
IHA-FFS-C-001	FlexFit Select	XX	7.12%	2.04%	4.48%	0.48%	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	0.146	1.079	1.023	0.921	0.921	1.279	XX	0.000	1.216	1.281
IHA-C1001	FlexFit Select	XX	7.12%	2.04%	4.48%	0.48%	XX	1.130	1.077	1.002	1.036	1.042	1.063	XX	0.000	0.000	0.000	0.000	0.000	0.000	XX	1.117	1.201	0.000
IHA-C-101	Encompass Essential	XX	7.12%	2.04%	4.48%	0.48%	XX	0.857	1.051	0.963	1.139	1.147	1.078	XX	0.904	1.140	1.035	0.956	0.956	1.289	XX	1.123	1.225	1.350
		XX					XX	0.913	1.101	1.023	1.059	1.065	1.078	XX	1.007	1.030	0.945	1.002	1.002	1.213	XX	1.107	1.192	1.299

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	X	Y				
1	<b>Data Collection Template</b>																											
2																												
3	Company Legal Name:		Independent Health Associatio												State:		NY											
4	HIOS Issuer ID:		18029												Market:													
5	Effective Date of Rate Change(s)		1/1/2014																									
6																												
7																												
8	<b>Market Level Calculations (Same for all Plans)</b>																											
9																												
10																												
11	<b>Section I: Experience period data</b>																											
12	Experience Period:		1/1/2012		to		12/31/2012																					
13			<u>Experience Period</u>		<u>Aggregate Amount</u>		<u>PMPM</u>		<u>% of Prem</u>																			
14	Premiums (net of MLR Rebate) in Experience Period:		\$328,366,257		\$490.74		100.00%																					
15	Incurred Claims in Experience Period		\$258,922,232		386.96		78.85%																					
16	Allowed Claims:		\$305,837,636		457.07		93.14%																					
17	Index Rate of Experience Period				\$457.07																							
18	Experience Period Member Months		669,120																									
19																												
20	<b>Section II: Allowed Claims, PMPM basis</b>																											
21			Experience Period		Projection Period:		1/1/2014 to 12/31/2014		Mid-point to Mid-point, Experience to Projection												24 months							
22			<u>on Actual Experience Allowed</u>		<u>Projection Period</u>		<u>Annualized Trend</u>		<u>Projections, before credibility Adjustment</u>				<u>Credibility Manual</u>															
23	<b>Benefit Category</b>		<b>Utilization per 1,000</b>		<b>Average Cost/Service</b>		<b>PMPM</b>		<b>Pop'l risk Morbidity</b>		<b>Other</b>		<b>Cost</b>		<b>Util</b>		<b>Utilization per 1,000</b>		<b>Average Cost/Service</b>		<b>PMPM</b>		<b>Utilization per 1,000</b>		<b>Average Cost/Service</b>		<b>PMPM</b>	
24	Inpatient Hospital		Days		430.54		\$2,514.86		\$90.23		1.000		1.000		1.019		0.999		429.74		\$2,610.96		\$93.50				\$0.00	
25	Outpatient Hospital		Services		9,804.13		\$93.84		76.67		1.000		1.000		1.034		1.016		10,121.47		100.37		84.66				0.00	
26	Professional		Services		15,920.62		\$94.02		124.74		1.000		1.000		1.011		0.987		15,510.22		96.12		124.24				0.00	
27	Other Medical		Services		13,661.99		\$38.66		44.02		1.000		1.000		1.020		1.015		14,066.70		40.23		47.16				0.00	
28	Capitation		Benefit Period		12,000.00		0.65		0.65		1.000		1.000		2.077		1.000		12,000.00		2.80		2.80				0.00	
29	Prescription Drug		Prescriptions		15,116.32		\$95.87		120.77		1.000		1.000		1.000		1.000		15,116.32		95.87		120.77				0.00	
30	Total								\$457.07														\$473.12				\$0.00	
31																												
32	<b>Section III: Projected Experience:</b>		Projected Allowed Experience Claims PMPM (w/applied credibility if applicable)																		100.00%		0.00%		<u>After Credibility</u>		<u>Projected Period Totals</u>	
33			Paid to Allowed Average Factor in Projection Period																						0.937		\$313,820,230	
34			Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM																						\$443.10		\$293,907,381	
35			Projected Risk Adjustments PMPM																						0.00		0	
36			Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM																						\$443.10		\$293,907,381	
37			Projected ACA reinsurance recoveries, net of rein prem, PMPM																						0.00		0	
38			Projected Incurred Claims																						\$443.10		\$293,907,381	
39																												
40			Administrative Expense Load																				12.15%		63.41		42,056,545	
41			Profit & Risk Load																				0.85%		4.44		2,942,227	
42			Taxes & Fees																				2.09%		10.91		7,238,247	
43			Single Risk Pool Gross Premium Avg. Rate, PMPM																						\$521.86		\$346,144,400	
44			Index Rate for Projection Period																						\$473.12			
45			% increase over Experience Period																						6.34%			
46			% Increase, annualized																						3.12%			
47			<b>Projected Member Months</b>																								663,294	
48																												
49	<b>Information Not Releasable to the Public Unless Authorized by Law:</b> This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.																											
50																												

**Product-Plan Data Collection**

Company Legal Name:  
 HIOS Issuer ID:  
 Effective Date of Rate Change(s):

**Independent Health Association**  
**18029**  
**1/1/2014**

State: **NY**  
 Market:

**Product/Plan Level Calculations**

**Section I: General Product and Plan Information**

Product		
Product ID:		
Metal:		
AV Metal Value		
AV Pricing Value		
Plan Type:		
Plan Name		
Plan ID (Standard Component ID):		
Exchange Plan?		
Historical Rate Increase - Calendar Year - 2		
Historical Rate Increase - Calendar Year - 1		
Historical Rate Increase - Calendar Year 0		
Effective Date of Proposed Rates		1/1/2014
Rate Change % (over prior filing)		
Cum'tive Rate Change % (over 12 mos prior)		
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!
Product Threshold Rate Increase %		#VALUE!

**Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)**

Plan ID (Standard Component ID):	Total	0
Inpatient	#VALUE!	
Outpatient	#VALUE!	
Professional	#VALUE!	
Prescription Drug	#VALUE!	
Other	#VALUE!	
Capitation	#VALUE!	
Administration	#VALUE!	
Taxes & Fees	#VALUE!	
Risk & Profit Charge	#VALUE!	
Total Rate Increase	#VALUE!	\$0.00
Member Cost Share Increase	#VALUE!	

Average Current Rate PMPM	#VALUE!	
Projected Member Months	0	

Section III: Experience Period Information

Premium Information	Plan ID (Standard Component ID):	Total	0
	Average Rate PMPM	#VALUE!	
	Member Months	0	
	Total Premium (TP)	\$0	\$0
	EHB basis or full portion of TP, [see instructions]	#VALUE!	
	state mandated benefits portion of TP that are other than EHB	#VALUE!	
	Other benefits portion of TP	#VALUE!	100.00%
Total Allowed Claims (TAC)			
Claims Information	EHB basis or full portion of TAC, [see instructions]	#VALUE!	
	state mandated benefits portion of TAC that are other than EHB	#VALUE!	
	Other benefits portion of TAC	#VALUE!	100.00%
	Allowed Claims which are not the issuer's obligation:	\$0	
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	
	Portion of above payable by HHS on behalf of insured person, as %	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	\$0	\$0
	Net Amt of Rein	\$0.00	
	Net Amt of Risk Adj	\$0.00	
Incurred Claims PMPM			
	#DIV/0!	#DIV/0!	
Allowed Claims PMPM			
	#DIV/0!	#DIV/0!	
EHB portion of Allowed Claims, PMPM			
	#DIV/0!	#DIV/0!	

Section IV: Projected (12 months following effective date)

Premium Information	Plan ID (Standard Component ID):	Total	0
	Average Rate PMPM	#DIV/0!	\$0.00
	Member Months	-	-
	Total Premium (TP)	\$0	\$0
	EHB basis or full portion of TP, [see instructions]	#VALUE!	
	state mandated benefits portion of TP that are other than EHB	#VALUE!	
	Other benefits portion of TP	#VALUE!	100.00%
Total Allowed Claims (TAC)			
Claims Information	EHB basis or full portion of TAC, [see instructions]	#VALUE!	
	state mandated benefits portion of TAC that are other than EHB	#VALUE!	
	Other benefits portion of TAC	#VALUE!	100.00%
	Allowed Claims which are not the issuer's obligation	\$0	
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	\$0	
	insured person, as %	#DIV/0!	#DIV/0!
	Total Incurred claims, payable with issuer funds	\$0	\$0
	Net Amt of Rein	\$0	
	Net Amt of Risk Adj	\$0	
Incurred Claims PMPM			
	#DIV/0!	#DIV/0!	
Allowed Claims PMPM			
	#DIV/0!	#DIV/0!	
EHB portion of Allowed Claims, PMPM			
	#DIV/0!	#DIV/0!	