

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
DEFINITIONS		<ul style="list-style-type: none"> a. Company refers to the licensed entity providing the insurance coverage reflected in the rate adjustment filing. b. A company’s commercial book of business includes all of the following: large group, small group, direct pay, Healthy New York, and Medicare Supplemental. It excludes all government programs, such as, Medicare, Medicaid, Family Health Plus, and Child Health Plus. c. Loss ratio refers to incurred claims divided by earned premiums for a given period of time. Incurred claims <u>includes</u> the impact of the Standard Direct Pay and Healthy New York stop loss pools 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. d. Market segment 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. 	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>e. Product street name refers to the product name as advertised to consumers, and the product name which consumers are most likely to use when communicating with the Department.</p> <p>f. Rate applicability period refers to the length of time in which the rates in a rate table are assumed to remain in effect.</p> <p>(i) Example 1: A non-rolling rate table is developed to be effective January 1, 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. Standardized earned premium is the earned premium for the period adjusted to assume that all premiums for the period are payable at the most current approved (or deemed approved) rate level, reflecting rate increases exclusive of rate changes due to contract language changes (i.e., excluding rate changes due to benefit revisions or members migrating to different plan designs since the impact of such changes would be automatically reflected in the earned premiums and incurred claims once such a change becomes effective). 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 3rd and 4th quarters 2012 and 1st and 2nd quarters 2013. The 2nd quarter 2012 rates have already been approved. Therefore, the 2nd 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 2nd quarter 2012 rate level. If the 2nd 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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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>ROLLING RATE STRUCTURE</p>		<ul style="list-style-type: none"> a. All rate filings for a rolling rate structure must include rolling rates for a 12 month issue/renewal period. 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>CHANGES TO PREVIOUSLY APPROVED RATE TABLES</p>		<ul style="list-style-type: none"> 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. b. A company can revise a previously approved non-rolling rate table provided that: <ul style="list-style-type: none"> (i) The proposed effective date of the rate table is at least 12 months after the effective date of the current rate table; or (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. 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 	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>submitted and approved that included quarterly rolling rate tables for 1st, 2nd, 3rd and 4th quarter of 2012. The company can not revise the 1st and 2nd quarter 2012 rate tables, but if the indicated criteria is met, can submit a new prior approval rate filing that includes rolling rates for 3rd and 4th quarter 2012 and 1st and 2nd 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>STANDARD EXHIBITS 1 - 7</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>Exhibit 1</p>		<p>General information about the rate adjustment submission.</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&H – 42), HMO (HMO – 44), Article 42 Life company (Life – 42), Article 41 property/casualty company (P&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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>	
Exhibit 2		<p>Summary of Average Claim Trend and Administrative Expenses Included in Current and Prior Rate Adjustment Filings.</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>	
Exhibit 3	Circular Letter No. 12 (2011)	<p>Narrative Summary.</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p align="center">explanation for each such product type. Each page of the narrative summary should be numbered (i.e., [page] of [pages]).</p>	
<p>Exhibit 4</p>		<p>Summary of Proposed Percentage Rate Change to Existing Rate.</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>Exhibit 5</p>		<p>Distribution of Contracts Affected by the Proposed Rate Adjustments.</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>Exhibit 6</p>		<p>Summary of Policy Form and Product Changes.</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>Exhibit 7</p>		<p>Historical Data by Each Policy Form Included in the Rate Adjustment Filing.</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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 1st, 2nd, 3rd, and 4th quarters of 2013. Rates are for a 12 month period. Indicate the average rate change percentage from the 1st quarter of 2012 rate tables to the 1st quarter 2013 rate tables.)</p> <ul style="list-style-type: none"> 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. 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. 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"> (i) Each experience period is to be for 12 months (or shorter if a new form). (ii) The ending date of the recent experience period cannot be earlier than 12 months before the proposed effective date of the earliest rate table included in the rate filing. (Example: The rate filing is for a non-rolling rate table to be effective July 1, 2013. The recent experience period cannot have an ending date earlier than June 30, 2012, i.e., 12 months prior to July 1, 2013.). (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. (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 	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>	
ACTUARIAL MEMORANDUM	11NYCRR 52.40(a)(1)	<p>Actuarial qualifications:</p> <p>a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and</p> <p>b. Meets the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</p>	
Justification of Rates	<p>§3231(e) §4308(c) 11NYCRR 52.40 11NYCRR 52.42 (HMOs) 11NYCRR 52.45 11NYCRR 59.5(b) 11NYCRR 360.11</p>	<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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>information for percentage rate changes implemented during the prior 24 months.</p> <p>(ii) For a rolling rate structure, the percentage change to the first rate table of the rolling rate structure included in the rate filing, from the immediately preceding implemented rolling rate table not included in the rate filing. Indicate the rolling rate periods of the rate tables used to develop this percentage change. If the percentage change between two corresponding rate tables is not uniform, indicate the minimum, maximum and average percentage change between those two rate tables. This comparison is to be done for each first table of a rolling rate structure included in the rate filing. (Example: The rate filing includes four quarterly rolling rate tables beginning 3rd quarter 2013. The change from each of the 2nd quarter 2013 rolling rate tables to the corresponding 3rd 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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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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"> (ii) If the source data is other than the actual claims experience, indicate the source of this data (e.g., from what publication, prepared by what organization), and the applicability of this source data. (iii) Discuss the credibility of such source data. (iv) Include an exhibit showing the source data and indicate all adjustments made to this source data to develop the projected incurred claims for the renewal rate applicability period. Provide this detail for each non-rolling rate table included in the rate filing, and/or for the first rate table of each rolling rate structure included in the rate filing (for base medical rate tables and for rider rate tables) for each permitted aggregation of policy forms (i.e., rating pool). Provide justification for each such adjustment. <p>f. Indicate the assumed annualized claim trend projection factors used to project the source data to the renewal rate applicability period (for the non-rolling rate tables and/or the first rate tables of a rolling rate structure) for each product within each permitted policy form aggregation (i.e., rating pool).</p> <ul style="list-style-type: none"> (i) Indicate the assumed annualized composite trend factors used for each base medical policy form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. Indicate the assumed composite annual trend factors used for each rider form (or permitted aggregation) and separately for the utilization and unit cost components of the composite trend. (ii) Provide justification for the assumed utilization, unit cost and composite annual trend factors. Discuss the impact and provide justification for any case mix change, intensity of service change, population/demographic change, adverse selection, or deductible leveraging component incorporated into the utilization and/or unit cost trend factor components. (iii) Clearly discuss how the annualized trend factors were applied to the source data to develop the projected data for the renewal rate applicability period. <p>g. Provide an actuarial justification of the proposed rate changes for each base medical policy form and each rider form, or permitted aggregation, included in the rate submission.</p> <ul style="list-style-type: none"> (i) Clearly show how the percentage change from the current rate table was developed, or how the revised premium rate was developed, for the non-rolling rate tables and/or the first rate tables of a rolling rate structure. (Example: for a rolling rate structure, how the percentage change from the existing 2nd quarter 2013 rate table to the proposed 3rd 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. 	
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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"> (ii) For each subsequent rate table of a rolling rate structure, show how the change between each of the successive rate tables was developed (e.g., the change from the 3rd quarter 2013 rate table to the 4th quarter 2013 rate table). Provide justification for these changes between the rolling rate tables. (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.. (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). (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. 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. 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 	
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NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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>REVISED RATE MANUAL PAGES</p>	<p>11NYCRR 52.40(e)(2) 11NYCRR 52.45(f) 11NYCRR 59.5(b)</p>	<p>Rate Manual.</p> <p>a. Table of contents.</p> <p>b. Rate pages, including a page indicating the composition of each rating region.</p> <p>c. Insurer/corporation name on each consecutively numbered rate page.</p> <p>d. Identification by form number of each policy, rider, or endorsement to which the rates apply.</p> <p>e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.</p> <p>f. Description of revised rating classes, factors and discounts, as applicable.</p> <p>g. Examples of rate calculations, i.e., how the rate tables and formulas included in the rate manual are used to calculate the final rate for a given benefit design.</p> <p>h. Commission schedule(s) and fees.</p> <p>i. Underwriting guidelines and/or underwriting manual, to the extent applicable.</p> <p>j. Expected loss ratio(s).</p> <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>NOTICES TO POLICYHOLDERS Initial & Final</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>	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

<p>HHS JUSTIFICATION PART I (Unified Rate Review Template) AND PART II (Consumer Disclosure)</p>	<p>PPACA §1003</p>	<ol style="list-style-type: none"> 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. 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. 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). 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. 	
<p>PUBLIC DISCLOSURE OF THE RATE APPLICATION</p>		<p>Posting a Redacted Version of the Rate Adjustment Application to the Department’s Website.</p> <ol style="list-style-type: none"> 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). b. The Department will accept redaction of only the following information in the rate application: <ol style="list-style-type: none"> (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 (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. 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 	

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

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

		<p>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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