

EXHIBIT 3: NARRATIVE SUMMARY

Company Name: HealthNow NY Inc.
NAIC Code: 55204
SERFF Tracking #: HLTH- 128574307

Submit a Narrative Summary explaining the reason(s) for the proposed rate adjustment. The purpose of this Narrative Summary is to provide a written explanation to the company's policyholders to help them to understand the reason(s) why a rate increase is needed.

- The Narrative Summary will be a public document and will be posted on the Department's website and furnished by the Department to the public upon request.

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It is strongly encouraged that the company submit the Narrative Summary to the Department ten (10) days before submitting a rate adjustment application. It is recommended that the company include a draft of the narrative summary with a draft of the initial notice in a "Prior Approval Prefiling" submitted to the Department through SERFF.

- 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 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) made to the Narrative Summary subsequent to the posting is to be submitted to the Department with the specific change(s) identified.

- The Narrative Summary should include, but not be limited to, the following information:
 - 1) The name of the company submitting the rate adjustment request.
 - 2) A summary of the proposed rate adjustments.
 - 3) A description of which policyholders are affected by this rate adjustment application. The rate adjustment may only affect certain policyholders in a 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 mm/dd/yyyy – mm/dd/yyyy).
 - 4) The product street name is the product name as advertised to consumers (i.e., as consumers are likely to refer to this product/policy form when communicating with the Department).
 - 5) The effective date of the proposed rate adjustments and an indication of when the rate change would affect policyholders.
For example:
 - (a) For a non-guaranteed rate structure: All policyholders will receive the rate adjustment on mm/dd/yyyy.
 - (b) For 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.
 - 6) The number of policyholders/members affected by the proposed rate adjustment(s); aggregated across all market segments and products affected by the rate adjustments submission.
 - 7) An explanation, in plain-language, as to why it is necessary to request such rate changes. As appropriate, a separate explanation should be provided for each market segment. Where the rate increases are not the same for each product type within a market segment, the company should provide a separate explanation for each such product type.
- Each page of the Narrative Summary should be numbered (i.e., [page] of [pages]).



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

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

NAIC #: 55204
SERFF Tracking #: HLTH-128574307

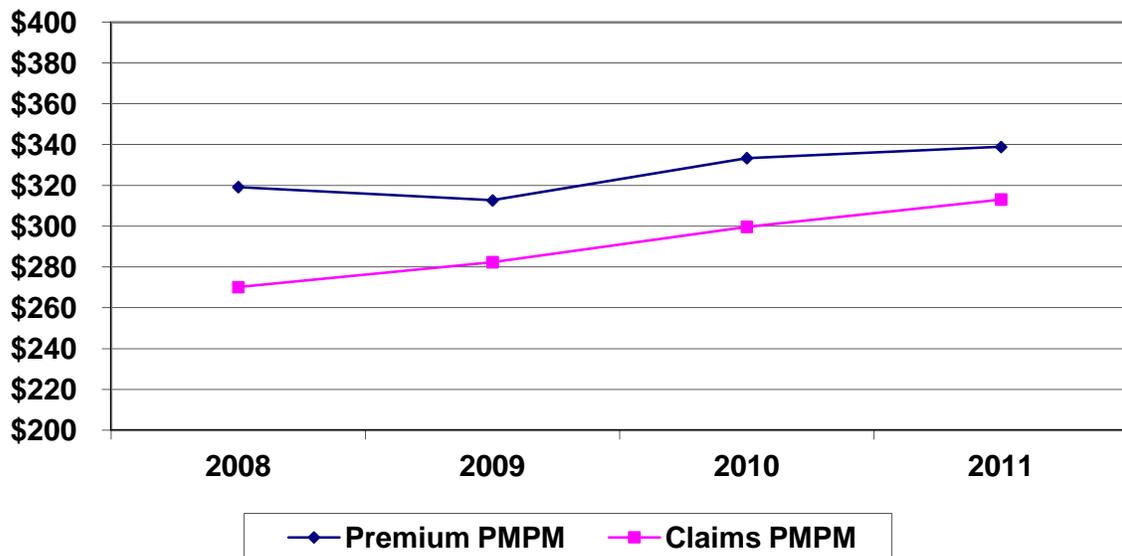
TO BE EFFECTIVE UPON 2013 RENEWAL DATE

THIS APPLICATION IS FOR OUR COMMUNITY RATED PRODUCTS

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

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

History of Increases





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

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

2. Who is affected and when.

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

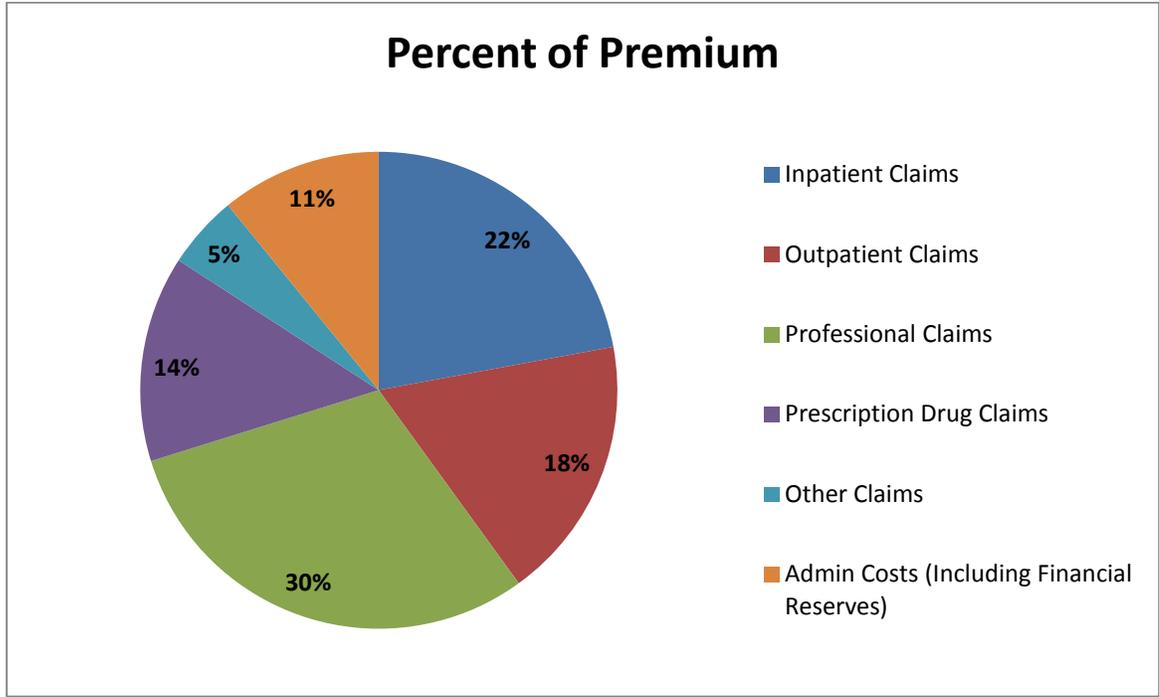
For Medicare Supplement customers, the rate change will be effective 1/1/2013 and will apply until a subsequent rate change is requested and implemented.

The estimated total number of members affected by the rate change based on current membership is 2,320.

3. Where premium dollars go.

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

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



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

A. Claims Trends. How many medical services members use – doctor visits, prescriptions, surgeries, x-rays, lab tests, hospital stays, etc. is part of this calculation. We measure the numbers of services used per 1,000 members to calculate usage rates. In addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones used last year, the amount we pay rises. Finally, the federal government may make changes such as increasing the Part A and Part B deductibles or changing the rates that Medicare pays for various services. In general, we expect the combined impact on claims in our region will be as follows:

Claims Trend	2012 (Proj ²)	2013
Medical	4.8%	4.8%
Prescription Drug (Plan H)	1.5%	1.5%

B. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, and detecting fraud and abuse. Our actual/anticipated per member per month administrative costs (as reflected in our premium rates) are as follows:

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



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Market	2011	2012 (Proj)	2013
Medicare Supplement	\$71.46	\$59.73	\$55.31

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

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

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

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

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

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

6. Our Finances.

We maintain financial reserves for the protection of our customers. These are monies we have in the bank or other accounts so that funds are available when there is a surge in claims or for any other reason that we need to reach into our bank accounts in order to pay claims for our members in the event current premiums are not sufficient to pay current claims and expenses. Reserves are measured as a percentage of our annual premiums. We are a not-for-profit insurer, so none of the funds in our reserves are used to pay stockholders or dividends to investors. These reserves are funded by gains from our product portfolio and income from investment of these reserves in fixed income and other securities. As of December 31, 2011, our corporate reserves were 22.1% of annual premium. This was a \$39 million decline from December 31, 2010, when they were 23.7%.

There are a few financial measures that directly impact pricing.

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

Loss Ratios	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Med. Supp.	87%	85%	89%	82%



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

Gain/Loss	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Med. Supp.	-19.7%	-10.0%	-13.1%	-4.4%

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

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

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

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

C. Hospital Readmission Reduction. Prior authorization processes ensure that the member having the right procedure performed by the right professional in the right place at the right time. We do extensive medical review on claims to make sure the procedure would be medically necessary.

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

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

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

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



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

For example, assume the product pool consists of 98 members with low health costs (\$5 each) and two persons with high costs (\$55 each), and thus total claims expenses of \$600.³ That produces an average cost of \$6 per member. If 8 of the low cost members depart to buy other coverage or drop their insurance, there are now 90 members with low costs and two persons with high costs. The average cost rises to \$6.90 per member⁴. That is a 15% increase in premium due solely to the changed composition of our insurance pool. Then 10% or so is added to account for the rising price of prescriptions, hospitals etc., (see section 4 above) and thus the premium increase becomes 25%. The impact of this constant factor in premium setting is made much worse when rising health care costs, and a sluggish economy, cause more people than usual to drop their coverage, or seek other, lower cost products.

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

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

The remaining page(s) show the rate changes requested in the rate filing.

³ $(98 * 5 = 490) + (2 * 55 = 110) = \600 total. Divided by 100 members = \$6 per member.

⁴ $(90 * 5 = 450) + (2 * 55 = 110) = \560 total. Divided by 92 members = \$6.90 per member. \$6.90 is 15% more than \$6.00.



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Proposed Rate Adjustments

Modernized Medicare Supplement Plans June 1, 2010, and later effective dates		
Plan	Current Monthly Rate	Proposed Monthly Rate
A	\$149.40	\$161.84
B	\$186.41	\$201.94
C	\$229.68	\$248.81
F	\$230.78	\$250.00
Hi-Ded F	\$99.69	\$107.99
M	\$196.28	\$212.63
N	\$188.95	\$204.69

Standardized Medicare Supplement Plans May 1, 2010, and earlier effective dates		
Plan	Current Monthly Rate	Proposed Monthly Rate
A	\$149.40	\$152.95
B	\$186.41	\$190.84
C	\$229.68	\$235.13
E	N/A	N/A
F	N/A	N/A
Hi-Ded F	N/A	N/A
H w/o Rx Benefit	\$214.78	\$232.67
H w Rx Benefit	\$298.92	\$323.82



BlueShield of Northeastern New York
 30 Century Hill Drive • Latham, New York 12110

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

NAIC #: 55204
 SERFF Tracking #: HLTH-128574307

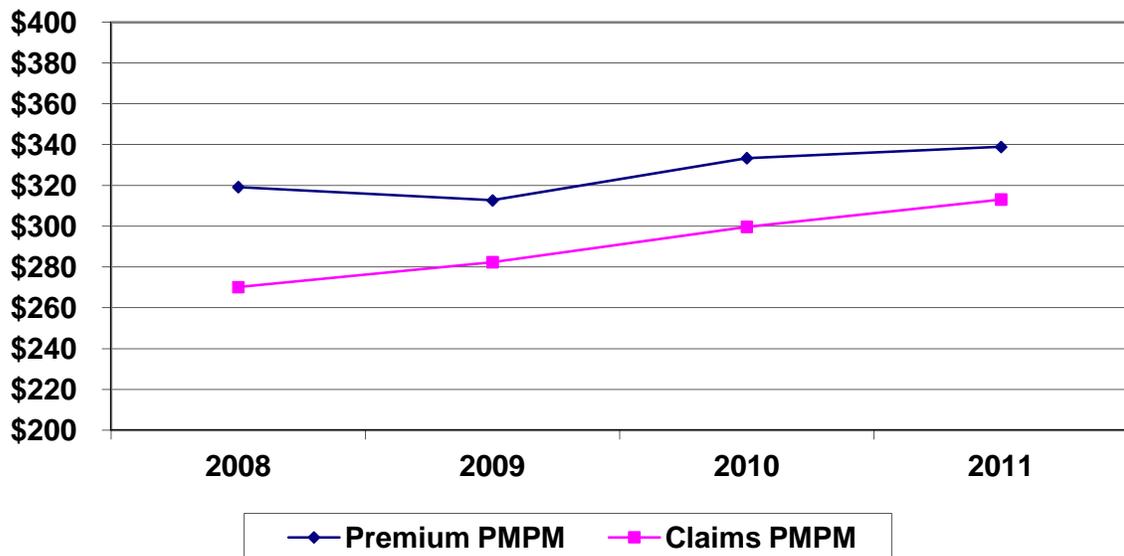
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1. Introduction. BlueShield of Northeastern New York has submitted this application to modify premium rates. We are well aware of the difficulty that all businesses and individuals have in paying premiums. The trend of constantly rising health care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

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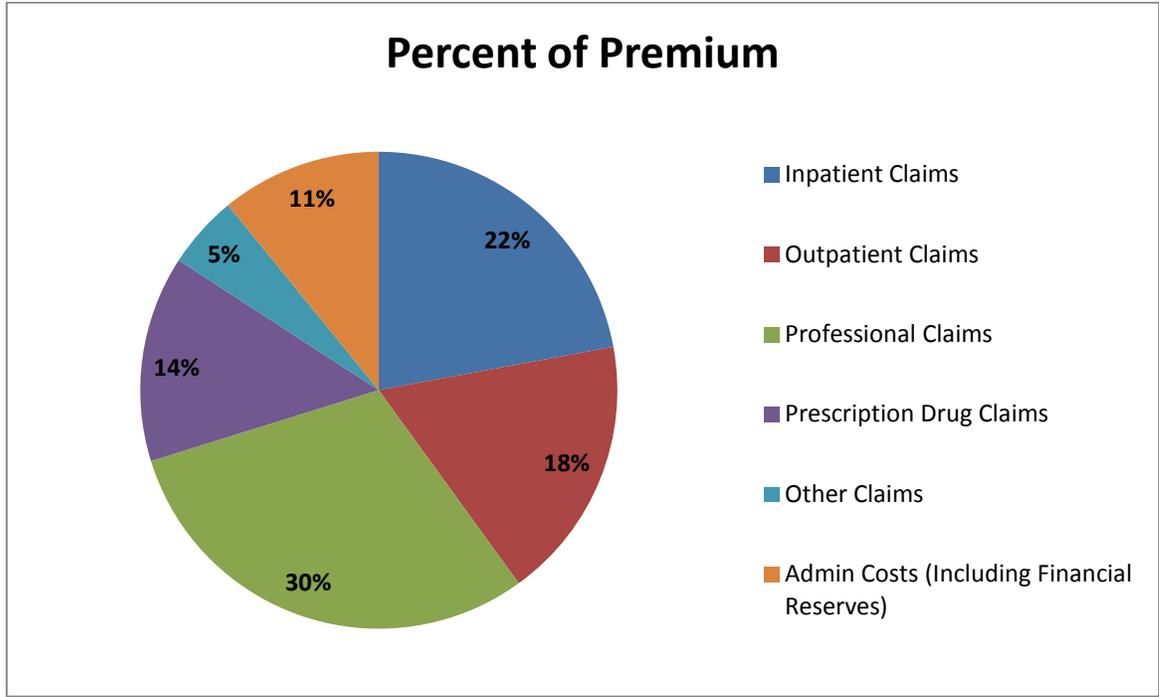
For Medicare Supplement customers, the rate change will be effective 1/1/2013 and will apply until a subsequent rate change is requested and implemented.

The estimated total number of members affected by the rate change based on current membership is 1,107.

3. Where premium dollars go.

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

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B. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, and detecting fraud and abuse. Our actual/anticipated per member per month administrative costs (as reflected in our premium rates) are as follows:

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



Market	2011	2012 (Proj)	2013
Medicare Supplement	\$68.70	\$58.39	\$55.31

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

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

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

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

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

6. Our Finances.

We maintain financial reserves for the protection of our customers. These are monies we have in the bank or other accounts so that funds are available when there is a surge in claims or for any other reason that we need to reach into our bank accounts in order to pay claims for our members in the event current premiums are not sufficient to pay current claims and expenses. Reserves are measured as a percentage of our annual premiums. We are a not-for-profit insurer, so none of the funds in our reserves are used to pay stockholders or dividends to investors. These reserves are funded by gains from our product portfolio and income from investment of these reserves in fixed income and other securities. As of December 31, 2011, our corporate reserves were 22.1% of annual premium. This was a \$39 million decline from December 31, 2010, when they were 23.7%.

There are a few financial measures that directly impact pricing.

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Med. Supp.	87%	85%	89%	82%



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

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

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

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For example, assume the product pool consists of 98 members with low health costs (\$5 each) and two persons with high costs (\$55 each), and thus total claims expenses of \$600.³ That produces an average cost of \$6 per member. If 8 of the low cost members depart to buy other coverage or drop their insurance, there are now 90 members with low costs and two persons with high costs. The average cost rises to \$6.90 per member⁴. That is a 15% increase in premium due solely to the changed composition of our insurance pool. Then 10% or so is added to account for the rising price of prescriptions, hospitals etc., (see section 4 above) and thus the premium increase becomes 25%. The impact of this constant factor in premium setting is made much worse when rising health care costs, and a sluggish economy, cause more people than usual to drop their coverage, or seek other, lower cost products.

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

The remaining page(s) show the rate changes requested by region, product, and group size in the rate filing.

³ $(98 * 5 = 490) + (2 * 55 = 110) = \600 total. Divided by 100 members = \$6 per member.

⁴ $(90 * 5 = 450) + (2 * 55 = 110) = \560 total. Divided by 92 members = \$6.90 per member. \$6.90 is 15% more than \$6.00.



BlueShield of Northeastern New York
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Proposed Rate Adjustments

Modernized Medicare Supplement Plans June 1, 2010, and later effective dates		
Plan	Current Monthly Rate	Proposed Monthly Rate
A	\$156.35	\$169.37
B	\$194.66	\$210.87
C	\$233.48	\$252.93
F	\$234.52	\$254.05
Hi-Ded F	\$99.26	\$107.53
M	\$200.17	\$216.84
N	\$189.38	\$205.15

Standardized Medicare Supplement Plans May 1, 2010, and earlier effective dates		
Plan	Current Monthly Rate	Proposed Monthly Rate
A	\$156.35	\$169.37
B	\$194.66	\$210.87
C	\$233.48	\$252.93
E	N/A	N/A
F	N/A	N/A
Hi-Ded F	N/A	N/A
H w/o Rx Benefit	\$219.32	\$237.59
H w Rx Benefit	\$311.75	\$337.72

Pre-Standardized Medicare Supplement Plans May 1, 1992, and earlier effective dates		
Plan	Current Monthly Rate	Proposed Monthly Rate
Golden Plus Basic	\$184.98	\$200.39
Golden Plus 4	\$234.52	\$254.05