6/13/2014
APPLICATION TO THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES
FOR A PREMIUM ADJUSTMENT

NAIC #: 55204
SERFF Tracking #s: HLTH-129576705, HLTH-129576737

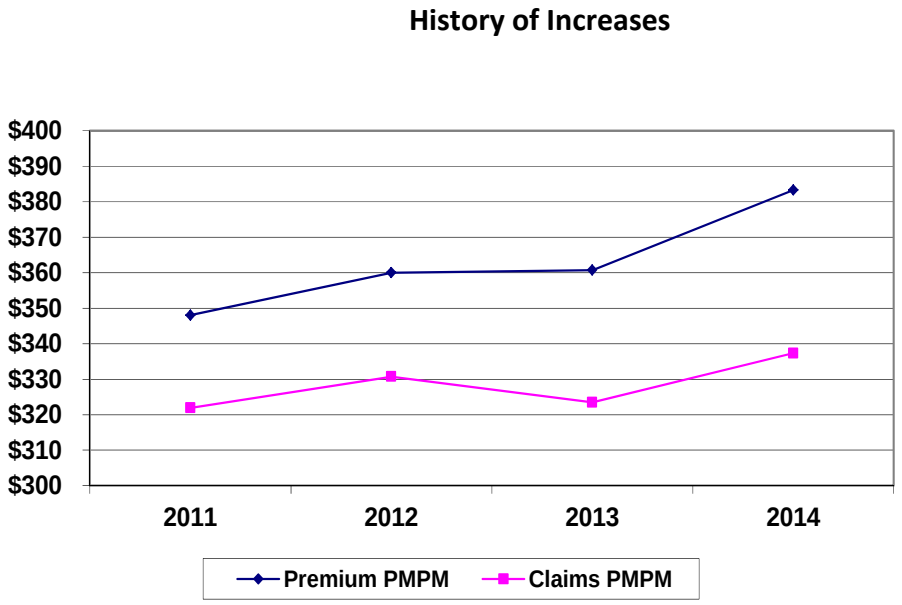
TO BE EFFECTIVE UPON 2015 RENEWAL DATE

THIS APPLICATION IS FOR SMALL GROUP COMMUNITY-RATED PRODUCTS

1. Introduction.

We have submitted this application to modify premium rates. The trend of constantly rising health care costs has been ongoing for some time. As a company that listens carefully to our members, we understand the difficult choices that rising premiums can cause among our members. We prepared this application after giving serious consideration of the impact of these increases and after implementing measures to reduce costs as much as possible.

Consistent with experience around the country, the annual rise in premium rates correlates closely with the annual rise in health care costs. This includes hospital, doctor, and other services. The chart below demonstrates that premiums rise to follow the increasing per-person cost of care incurred by our community-rated members. The costs are presented on a per member per month basis (PMPM).



More information is provided on the following pages. We hope that the review of these materials will help explain why rises in premium costs are occurring.

We have done our best to limit increases in health care costs by:

- Implementing programs designed to reduce medical waste and to help our members to better manage their health to prevent costly medical conditions (See section 8 for details on these programs.)
- Negotiating with doctors, hospitals, and other providers to limit their annual fee increases. However, we have been cautious during these negotiations because it is important that providers receive sufficient payment from us to assure they are ready, willing, and able to provide the quality care our members deserve.

2. Members affected.

This rate change application affects only the members enrolled in small, community-rated group products (2-50 employees). "Community rated" means that all members with the same coverage have the same premium; premiums do not vary by age, sex, medical conditions, or usage of health care services. Most other groups and government programs are subject to different premium setting rules and a different approval process than those that apply to this application.

The rate change will be effective upon renewal dates in 2015. The rates vary by the calendar quarter in which the group renews and are guaranteed for the 12-month period starting on the renewal date.

Based on current membership numbers, we estimate that 53,000 members will be affected by the rate change.

We have elected to sell products on the ACA health reform exchange for certain rating regions in which we do business. In New York this is called the New York State of Health.

Our small group community-rated products are offered in the following New York State defined rating regions within the listed counties:

Region 1 (Albany Area): Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington

Region 2 (Buffalo Area): Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

Region 5 (Rochester Area): Monroe, Wayne

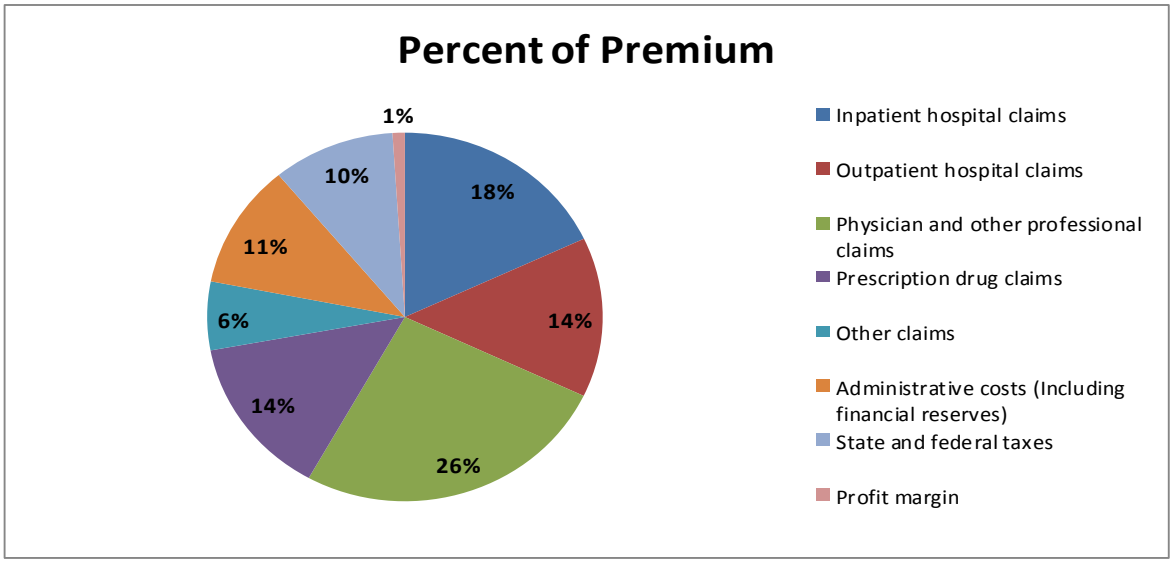
Region 6 (Syracuse Area): Chemung, Onondaga

Region 7 (Utica/Watertown Area): Clinton, Essex, Oswego

The New York State defined rating regions may contain more counties than those in which we operate. Any specific product we offer may be available only within a subset of our rating regions. In addition, any specific product offered within a rating region may only be available in a subset of the listed counties.

3. Where premium dollars go.

Percentage of premiums allocated to different cost categories in a typical year.



4. Rising health care costs.

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

A. Use of services. How many medical services members use—doctor visits, prescriptions, surgeries, X-rays, lab tests, hospital stays, etc.—is part of this calculation. We measure the number of services used per 1,000 members to calculate usage rates.

Sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if a doctor uses more complicated and expensive tests instead of the less costly tests used last year, the amount we pay rises. In many years, there is an increase **both** in the number of services used on average and in the intensity/cost of those services.

In general, we expect that utilization will change in our region as follows:

Utilization Changes	**2014**[1]	**2015**[2]
Inpatient hospital	-2.4%	0.9%
Outpatient hospital	0.6%	2.1%
Physician / professional	0.3%	0.9%
Prescription drug	-3.4%	-3.5%

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services. These are the average fee increases the various categories of providers agreed to accept:

Price Changes	**2014**	**2015**
Inpatient hospital	6.1%	1.7%
Outpatient hospital	5.5%	2.9%
Physician / professional	0.6%	1.4%
Prescription drug	9.3%	8.2%

[1] The current year is not yet concluded so our data at the time of this application is a projection for all 2014 statistics.
[2] All 2015 statistics are based on our most recent projections.

C. Copay/deductible leveraging. If a plan design has fixed-dollar deductibles and copays rather than a percent coinsurance, the costs to the insurer will increase at a higher rate when the price of medical services increases.

Example:
Year 1: The fee for an office visit is $100. The member with the copay plan pays a copay of $25 and we would pay the remaining $75.

Year 2: The doctor's fees increases 5% to $105. The member still pays a copay of $25 but now we pay the remaining $80, which is a 6.67% increase for us. This additional 1.67% increase above the 5% increase in fees is called leveraging. We expect this to impact the small group community-rated products as follows:

Leveraging	2014	2015
Small Group	0.9%	0.7%

D. Population Demographics. Different age and gender combinations typically have different average costs to insure. Because community rating does not allow us to vary rates by age or gender, the costs for everyone must go up if the mix within a product, or our entire block of business, shifts toward more expensive combinations. We expect this to impact the small group community-rated products as follows:

Medical Demographic Shift	2014	2015
Small Group	0.7%	0.0%

Prescription Drug Demographic Shift	2014	2015
Small Group	0.9%	0.0%

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

Our actual/anticipated per member per month administrative costs (as reflected in our small group community-rated products) are as follows:

Administrative Costs	2013	2014	2015
Small Group	$42.37	$45.51	$39.21

5. Changes due to the federal Affordable Care Act (ACA).

The benefits we cover have been changed in many instances to conform to the benefits required under the ACA. We are required to cover all essential health benefits, which is a set of benefits all plans statewide must cover in the small group community-rated market. The cost of those additional benefits (compared to the benefits we covered in 2013) is approximately 2% of our small group premium.

6. State health care taxes and federal ACA fees.

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 $12.7 million on our community-rated business during 2013.

B. An "assessment" on each person (life) we cover for persons residing in New York State. The assessment is larger for family coverage than for single persons. The assessment varies by geographic region of the state. We paid approximately $2.8 million on our community-rated business during 2013.

The surcharges and assessments are mandated by New York's Health Care Reform Act of 1997 (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. A fee to fund the operations of the New York State Department of Financial Services (formerly the Insurance Department), as it is funded by insurers rather than by state income or typical state taxes. We paid approximately $2.6 million on our community-rated business during 2013.

The combination of all our payments of the state health care taxes above constitutes approximately 5% of our community-rated premiums.

The federal Affordable Care Act (ACA) has some financial implications for the increased rates we propose. Under the ACA we must pay a health insurance tax to the federal government. Based on our best estimates, we have reflected this tax in our premiums as an expense 2.5% of premium.

The ACA contains provisions designed to balance the insurance market so that premiums do not increase significantly as a result of one insurer covering far more high cost members than are covered by an average insurer. New York has had a similar system for many years which will now be replaced by the federal system. The federal system requires insurers who enroll more healthy individuals than the average insurer to pay funds to the federal government. The federal government then pays those funds to insurers who enroll more old and sick individuals than the average insurer. We project that the populations we insure will be healthier than the New York average and thus we project we will pay funds into the federal risk adjustment process. The payment we must make to the federal government will increase our premiums by approximately 2% from what those premiums would otherwise be. The new premiums we propose already take into account the increase in premium rates.

The ACA also contains a transitional reinsurance program designed to protect insurers in the individual market from some high claims costs that might not be taken into account by the risk adjustment process. The program is funded by a fee on health insurers. For 2015, we will pay $44 per enrollee per year in the small group community-rated market. The reinsurance receipts we receive from this program subsidize our individual market coverage, paying up to 50% of our claims that exceed $70,000 per enrollee.

The ACA also contains provisions to balance out unusually large profits or losses insurers may incur during the implementation of the ACA. Because these provisions are designed to protect against mispricing, we have not built any assumptions regarding their impact into our rates.

In total, the ACA expenses account for approximately 6% of our community rated group premiums.

The combination of both the state health care taxes and the federal ACA fees constitutes approximately 11% of our community-rated premiums.

7. Our finances.

We maintain financial reserves for the protection of our customers. This money is either 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 pay claims for our members in the event current premiums are not sufficient to pay 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, 2013, our corporate reserves were 24.0% of our annual premiums.

There are a few financial measures that directly affect 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" or MLR. Our MLR on small group community-rated business subject to this annual rate application is as follows:

Loss ratios	2013	2014	2015
Small Group	86%	84%	88%

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 subject to this annual rate application is as follows:

Gain/Loss	2013	2014	2015
Small Group	-3.7%	1.0%	1.0%

8. Our Cost Control and Quality Improvement Efforts.

We have implemented several initiatives to improve the health of our members and ensure they receive the high quality medical care they deserve.

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:

- Asthma
- Back pain
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease
- Diabetes

B. Coordination of Care. These care management programs are designed to improve the health outcomes and satisfaction of our members through collaborative relationships with the members and their providers. We enable our members to make informed health care decisions and help them navigate through their treatment plan. This ensures the care that they receive is appropriate, high in quality, and cost effective.

C. Hospital Readmission Reduction. Preauthorization processes ensure that a member has 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 is medically necessary.

D. Improving Patient Safety and Reducing Medical Errors. Our Medical Economics staff analyzes information, which allows us to contact members who may need assistance with managing their quality of care, ensuring they do not get readmitted to the hospital, or coordinating a plan of care with their physician.

E. The Quality Improvement Program. Continuously assesses and recommends improvements for the care delivered by our participating practitioners/providers.

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

G. Fraud detection. It is an unfortunate reality that some customers and providers submit claims for services that were not delivered, or for amounts higher than what is appropriate. Our fraud detection staff conducts audits of claims payments, and works with the Department of Financial Services and local prosecutors to protect our members from these costs.

9. 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 auto 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.

> **Example:** Assume the product pool consists of 98 members with low health care costs ($5 each) and two members with high costs ($55 each), and thus total claims expenses of $600.
>
> - (98 x $5 = $490) + (2 x $55 = $110) = $600 total
> - Divided by 100 members = $6.00 average cost per member.
>
> If eight of the low-cost members buy other coverage or drop their insurance, there are now 90 members with low costs and two members with high costs.
>
> - (90 x $5 = $450) + (2 x $55 = $110) = $560 total.
> - Divided by 92 members = $6.90 new average cost per member.
>
> That's a **15% increase** in premiums due solely to the changed composition of our insurance pool.
>
> Another 10% or so is added to account for the rising price of prescriptions, hospitals etc., and (see section 4 above) and then the premium increase becomes 25%.

The affect of this constant factor in premium setting is magnified when rising health care costs and a sluggish economy cause more people than usual to drop their coverage, or seek other, lower-cost products.

Another key factor is that insurance premiums are an average. We must insure a great many relatively healthy persons in order to balance out the healthcare costs of the relatively few people (in any given year) who incur high health care costs. Approximately 20% percent of the people we insure incur 85% of our total health care costs (an approximate average of $11,500 per person, per year). The other 80% of the people we insure incur merely 15% of our total health care costs (an approximate average of $550 per person, per year). Therefore it is easy to see why a large proportion of the people we insure believe their premiums are high in relation to the health care costs they personally incur. On the other hand, when any of our customers become seriously ill and join that small minority of our customers whose health care costs are higher than their premiums, they are reminded of the averaging effect of insurance.

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

10. Conclusion.

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

Accompanying this narrative is the NYS Exhibit 13 which provides a numerical summary of selected information from this rate filing and prior rate filings.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company HealthNow New York Inc.
NAIC Code: 55204
SERFF Trac HLTH-129576737
Market Segment: Small Groups On Exchange

1) Please complete this Narrative Summary and Numerical Summary for each market segment for which you are submitted a rate filing.
2) The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment.
3) The purpose of the Narrative Summary is to provide a written explanation to the company's policyholders to help them understand the reasons why a rate increase is needed.
4) The purpose of the Numerical Summary is to provide a clear and simple overview of the requested rate adjustment.
5) These Summaries will be public documents and will be posted on DFS's website and furnished by DFS to the public upon request.
6) The company should submit the these Summaries to DFS ten (10) days before submitting a rate adjustment filing.
7) A draft of these Summaries and of the Initial Notice must be included in a "Prior Approval Prefiling" submitted to DFS via SERFF.
8) Once reviewed by DFS, these Summaries must be posted to a location on its website that is publicly available and accessible without the need for a user ID/password.
9) Links should be provided on key pages of the company's website so that the information may be easily located.
10) Any change(s) made to the Narrative Summary/Numerical Summary subsequent to the posting must be submitted to DFS with the specific change(s) identified.
11) This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2014 and 2015 Premium Rates:

1) Average Monthly Premium Rates for Individual Only on Individual Plans and First Quarter Rates for Employee Only on Small Group Plans.
2) Premium Rates are Average Arithmetic Premium Rates for All Plans Combined and for all Regions combined.
3) Premium Rates are with Through Age 29, with Domestic Partner and with Family Planning Coverage.
4) Premium Rates for 2015 should be Consistent with the Premium Rates reflected in Exhibit 23.
5) Premium Rates for 2014 should be on a Consistent Basis as the Premium Rates for 2015.

	Platinum	Gold	Silver	Bronze	Catastrophic
2014 Premium Rates	606.88	575.14	479.03	402.10	N/A
2015 Premium Rates	622.99	507.26	412.42	346.67	N/A

B. Weighted Average Annual Percentage Requested Adjustments [Per Exhibit 14A for Individual Plans and Exhibit 14B for Small Group Plans]*:

	2014 to 2015
Requested Rate Adjustment	-2.1%

C. Weighted Average Annual Percentage Requested Adjustments for each of the Past Three Years [Per Exhibits 4A-4D] [If Applicable]*:

	2011 to 2012	2012 to 2013	2013 to 2014
Average Rate Adjustment	12.3%	6.7%	N/A

D. Average Medical Loss Ratios [MLR] for All Policies Impacted [Ratios of Incurred Claims to Earned Premiums] [If Applicable]*:

	2011	2012	2013
MLR	90%	87%	86%

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2014-15 and Comparable Exhibits for 2013] [If Applicable]*:

	2013	2014	2015
Annual Claim Trend Rates	7.0%	6.0%	4.5%
Expense Ratios	12.4%	14.7%	14.0%
Pre Tax Profit Ratios	1.7%	1.3%	1.3%

* If product was not offered in a particular year, indicate "N/A" in the applicable box.