

Request of:

Excellus Health Plan, Inc. doing business as

- **Excellus BlueCross BlueShield**
- **Univera Healthcare**

To:

The Department of Financial Services of the State of New York

For approval of Small Group and Individual health plan community rate increases in 2017

Filed: on or about May 9, 2016

NARRATIVE SUMMARY

Excellus Health Plan, Inc. (NAIC code number 55107) has applied to the Superintendent of the Department of Financial Services to adjust premium rates for its community-rated small group and individual health plans.

OVERVIEW

The proposed rate adjustments leading to increases are based on the cost and utilization of medical care and the under-funding of cost trends from previously approved rates by the state.

The rates being sought reflect a decrease in total operating expenses of 21.5%. Operating expenses for 2017 are budgeted at \$149.8 million, a \$40.9 million decrease from the 2016 filing.

The rates requested for 2017 contain a 2% operating margin, intended for the health plan to maintain sufficient reserves and to support a risk based capital ratio within a reasonable target range. The health plan reported operating losses in 2013 and 2014.

Excellus Health Plan and related companies ("EHP") provide health insurance and administrative services for about 1.5 million upstate New Yorkers in 39 counties. The proposed premium rates affect about 222,000 members or 14.9 percent of the health plan's total membership. Its proposed rates are subject to review by the New York Department of Financial Services pursuant to section 4308 (c) of the New York Insurance Law. The Department may approve the proposed rate increase as requested, modify the proposed rate increase, or disapprove the proposed rate increase in its entirety. By law, the determination of rates by the Department shall be supported by sound actuarial assumptions and methods.

The rate application will be filed with the Department on or about May 9, 2016. The actual rate increases approved by the Department will be communicated to the impacted parties at least 60 days prior to the date the new rate is implemented for the subscriber. EHP policyholders with renewal dates during 2017 would, if approved, receive the indicated rate adjustments on their next anniversary date on or after January 1, 2017.

Excellus Health Plan is required by New York State law to develop rates that assume at least 82% of premium revenue will be spent on health care costs in the direct pay and small group markets, be actuarially sound, cover all claim costs, and provide a contribution to ensure adequate reserves. The percent of premium attributable to claims is referred to as the Medical Loss Ratio ("MLR").

The actual MLR may vary over time based on changes in the amounts paid to hospitals, physicians, and pharmacies, along with how often members are receiving health care goods and services that are covered by their insurance. Excellus Health Plan's MLR has been and continues to exceed the statutory minimums. Under reporting requirements for 2015, the three-year cumulative MLR for the combined individual direct pay and small group plans is expected to exceed 90%. With the proposed rate adjustments, Excellus Health Plan's MLRs would remain above the minimum levels. In the event the MLR falls below the required minimum in either the small group or direct pay market, the health plan will refund any difference to policyholders in the affected market.

As explained further in this narrative, the requested rate increases are due primarily to the annual increases in the cost and utilization of medical care. Excellus Health Plan has attempted to limit the rate increases to the lowest amounts possible and exceed the minimum threshold of medical benefit payments as a percent of premium, while also preserving the financial integrity of the Plan.

Periodic rate adjustments are necessary to secure the ability of Excellus Health Plan, or any insurer, to produce sufficient revenue and reserves to assure continued coverage and claim payments both for current health care needs, and potential catastrophic cost situations. Excellus Health Plan's reserves vary from year to year based on actual health care costs incurred.

As of Dec. 31, 2015, the health plan had reserves equivalent to 66 days of claims and operating expense -- more than the minimum required by New York State law. These reserves are the "insurance" that assures payment even when costs run higher than anticipated, or emergencies or disasters occur, and should not be used as an alternative fund to temporarily reduce rate adjustments.

Seeking to achieve the minimum level of reserves permitted or a minimum risk-based capital ratio is not a sound financial practice for any health plan as it can ultimately lead to insolvencies. On the other hand, the health plan also does not seek to accumulate industry benchmark levels of reserves, or reach the top risk-based capital scores that have been achieved by some health plans. Rather, the community rate increases proposed are designed to achieve a small operating margin for the business to continue offering competitive and affordable access to health coverage in our communities.

In filing its rate application, Excellus Health Plan is sensitive to the fact that individuals and small businesses struggle to afford higher premiums, and therefore has filed increases that target just a 2% of premium operating margin. It is clear that an increase in premiums is necessary to assure the continued operations of the Plan and the viability of its product offerings. Because EHP already has a high MLR, failure to approve these rates would only lead to the need for even greater rate increases in the future.

FACTORS CONTRIBUTING TO THE PROPOSED RATE INCREASE

Escalating health care costs

The cost of health care services, equipment and products continues to be the primary reason for rate increases.

"Trend" is a very important consideration in determining the need for a premium rate adjustment. Upstate New York is not immune to national trends in health care costs given our state's population and demographics. Industry experts such as Aon Hewitt and Buck Consultants are forecasting a 7.6-8.1% medical benefit trend nationwide for 2016 in their National Trend Surveys. EHP is forecasting an overall medical benefit trend factor for its commercial fully insured business of 7.5% for 2016-2017. The trend forecast takes into account projected increases in costs attributed to what Excellus Health Plan pays out in claims expenses for hospital inpatient and outpatient care, professional services, pharmacy benefits and other goods and services. The health plan's anticipated changes in medical benefit spending are summarized as follows:

- Hospital inpatient, 6.6%
- Hospital outpatient, 6.4%
- Professional services, 3.9%
- Pharmacy, 14.0%, including:
 - Specialty Rx, 22.6%
 - Diabetic Rx, 21.4%
- Other medical goods and services, 4.9%

These trends do not include adjustments to base rates for previous rate increases that were insufficient to cover claims and operating expenses for some plan options.

Compounding effects of price and utilization

Health care costs for each of those benefit components take into account the compounding effects of both the price of the goods or services provided, as well as the quantity of the goods and services consumed.

For example, if the price of a service was \$100 in 2016 and the number of services provided was 100, the total amount spent in 2016 related to that service would be \$10,000. If the price of the service increases 10 percent in 2017 and the number of identical services rendered increases by 10 percent, the impact of both the price change and utilization increase is compounded for an overall increase in spending of 21 percent. (110 services x \$110 new price = \$12,100 spending, or a 21 percent increase over the prior year's spending of \$10,000.) The same impact on spending occurs if the intensity of services rises for treating patients.

The figures presented above of trend factors forecasted for each of the benefit components takes into account that compounding effect. And, the impact that each trend has to the overall cost of coverage is related to the proportionate size of the benefit component. For example, overall spending would rise faster as a result of a 5 percent increase in professional services versus a 5 percent increase in hospital inpatient costs because professional services represents a larger share of medical benefit spending.

Leveraging

For the lower priced high-deductible products, an additional rate adjustment is necessary in addition to trend. Benefit values of different products can change at different rates from year to year as deductibles and copayments remain unchanged. This occurrence is generally referred to as deductible leveraging and is a result of benefit costs increasing faster than trend when deductibles and copays are unchanged. While leveraging can occur in any product with fixed cost sharing components, it is most noticeable in high-deductible products. The table below is an example illustrating the leveraging effect:

	Current Year	Trend	Next Year	Year-to-Year % Change
Total Claims Cost	\$10,000	8.0%	\$10,800	8.0%
Annual Deductible	- \$2,000		- \$2,000	0.0%
Benefit Cost	= \$8,000		= \$8,800	10.0%
<i>Leveraging Impact</i>				2.0%

In this example, an 8 percent trend results in a benefit cost increase of 10 percent with a resulting leveraging impact of 2 percent, which is an additional driver of premium increases.

Risk Adjustment Program:

Under the federal health care reform law, a risk adjustment program was established as a permanent provision that applies to both the individual and small group insurance markets. This federal program assesses a charge on health plans that have low-risk members and uses the revenue to compensate plans with higher risk members.

For EHP, anticipated payments into this program result in an increase to small group plans' premium rate increase by about 6.0% in 2017. For 2017, a reduction in the anticipated receivable from the same program result in an increase to the premium rate increase of individual direct pay plans by 2.7%.

Transitional reinsurance program for the individual market:

The federal law also created a temporary reinsurance program to help stabilize premiums in the direct pay market from disruption that may be caused by the implementation of federal reform. As scheduled, the program will no longer exist in 2017. The removal of these funds that were previously available through the reinsurance program will require a 5.1% premium rate increase for individual plans.

OPERATING EXPENSE AND QUALITY IMPROVEMENTS

A portion of what is reported to the state as "administrative expenses" is attributed to what Federal Health Reform considers "quality improvement expenses," meaning the federal government recognizes that these represent costs that lead to overall improvements in health care versus simply a routine business expense, and as a result will be considered a medical benefit expense for purposes of federal MLR calculations.

Those quality improvement expenses include such items as:

- Improvements in health outcomes brought about by case management and disease management programs,
- Actions taken to help prevent hospital readmissions through such things as discharge planning and counseling,
- Wellness and community health promotional activities, and
- Health information technology that is used to help measure clinical effectiveness and predictive modeling.

EHP's Operating expenses represent an average of 7.5% of premium for small group plans and individual plans. These expenses include quality improvement initiatives, but exclude federal and state taxes, fees and assessments, and broker commissions.

TAXES AND ASSESSMENTS

Insurance taxes and assessments are built into the costs of health coverage. In total, the New York taxes and assessments aggregate to 5.4 % of the 2017 small group and individual plans' premium. Federal taxes represent an additional 0.7% of the 2017 small group plan premium.

CONCLUSION

Based on all of the reasons explained above, EHP is requesting the Superintendent of the Department of Financial Services to grant it a premium rate adjustment averaging 12.3% for its community-rated small group plans, and 15.9% for its individual plans to take effect on January 1, 2017. Lower rates sought for Univera Healthcare reflect provider network adjustments that offset some medical trends.

EXHIBIT 13a: NUMERICAL SUMMARY AND RATE INDICATION CALCULATION

NUMERICAL SUMMARY

Company Excellus Health Plan, Inc.
NAIC Code: 55107
SERFF Tracking #: EXHP-130525117
Market Segment: Individual

- 1 Please complete the Numerical Summary below as well as the Narrative Summary (a separate attachment) for each market segment for which a rate filing is being submitted.
- 2 The Narrative Summary must be in plain English and should clearly and simply explain the reasons for the requested rate adjustment (This should be included in the provided blank template "2017 Exhibit 13b - Narrative Summary.docx")
- 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 (with the exception of the Rate Indication Calculation Section) 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 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 Pre-filing" 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 Rate Change Adjustment calculations between Year 2016 and 2017 should be based on the DFS Membership Survey data as of 3/31/2016.
- 12 This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2016 and 2017 Premium Rates:

- 1 Average Premium Rates are as calculated in Rows 26 of the appropriate columns in Exhibit 13c.
- 2 Premium Rates for 2017 should be Consistent with the Premium Rates reflected in Exhibit 23.

	Average Individual Rate Platinum	Average Individual Rate Gold	Average Individual Rate Silver	Average Individual Rate Bronze	Average Individual Rate Catastrophic
2016 Weighted Average Base Premium Rates	\$ 664.35	\$ 580.22	\$ 467.30	\$ 348.07	NA
2017 Weighted Average Base Premium Rates	\$ 779.57	\$ 680.82	\$ 545.88	\$ 388.87	NA

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

	2016 to 2017	2016 Weighted Average PMPM Rate All - Metals	2017 Weighted Average PMPM Rate All - Metals
Requested Rate Adjustment	15.89%	\$ 439.40	\$ 509.21

From Cells H-93 and Q-93 of Exhibit 13c

C. Weighted Average Annual Percentage Adjustments for each of the Past Two Years [Per Exhibits 14A or 14B as appropriate] [If Applicable]*:

	2014 to 2015	2015 to 2016
Average Rate Adjustment Requested	19.7%	13.0%
Average Rate Adjustment Approved	9.3%	5.9%

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

	2013	2014	2015
MLR	NA	63.8%	98.7%

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2015-2017 and Comparable Exhibits for 2015] [If Applicable]*:

	2015	2016	2017
Annual Claim Trend Rates	7.40%	8.78%	7.45%
Expense Ratios	15.60%	15.7%	10.8%
Pre Tax Profit Ratios	0.00%	2.00%	2.00%

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