One Liberty Plaza, New York, NY 10006, Telephone (212) 476 1000

REQUEST OF:

EMPIRE BLUE CROSS AND BLUE SHIELD

TO:

THE DEPARTMENT OF FINANCIAL SERVICES of the STATE OF NEW YORK

FOR APPROVAL OF COMMUNITY RATE INCREASES

Filed June 13, 2014

One Liberty Plaza, New York, NY 10006, Telephone (212) 476 1000

NARRATIVE SUMMARY
[DFS and policyholder – for public posting]

I. OVERVIEW

Empire Blue Cross and Blue Shield (Empire) has made an application to the Superintendent of Financial Services to adjust premium rates for health insurance available to small groups of 1 to 50 eligible employees.

These groups' employees and their covered dependents are combined, by long standing New York law, in what is known as a community rated pool. All members enrolled in the pool plans are guaranteed issuance of coverage and are charged the same premium rate as any other member for the health insurance product they select regardless of health status, age, sex, or other demographic factors other than the region of the State where they reside.

All medical, hospital, pharmacy, and other covered care and necessary administrative costs are also combined, by law, in the pool in order to determine appropriate premium rates. These premium rates must support sufficient, sustainable revenue and reserves for both current and future coverage costs related to community pool products on a stand-alone basis. Current approved rates for Empire's community pool products are inadequate for the rising costs incurred as provider charges continue to rise, utilization of services increases, and new taxes and fees are implemented.

The products specifically impacted by rate increases at this time are the small group products sold by Empire HealthChoice Assurance, Inc., (Empire's insurance company; NAIC code number 55093) and Empire HealthChoice HMO, Inc. (Empire's HMO company; NAIC code number 95433). These rate adjustments impact policies offered off-exchange (e.g., outside of the New York State of Health Marketplace). The actual rate increases requested are provided below. Empire's proposed rates are subject to review and approval by the New York Department of Financial Services (the Department), with the determination by the Department supported by sound actuarial assumptions and methods. The rate applications were filed with the Department on June 13, 2014 (SERFF numbers: AWLP-xxx for Empire HealthChoice Assurance, Inc and AWLP-yyy for Empire HealthChoice HMO, Inc). The actual rate increases approved will be communicated to the impacted parties upon completion of the Department's review and are scheduled to be effective January 1, 2015 upon group renewal.

Empire is required by New York State law to develop rates that are actuarially sound, assume at least 82% of premium revenue will be spent on health care costs, cover all claim costs, and also contribute to claims reserves. The percent of premium attributable to claims is essentially how much of the premium dollar is used to pay claims and is

referred to as the Medical Loss Ratio (MLR). The actual MLR may vary over time based on changes in the amounts charged by hospitals, physicians, and other providers, as well as, the increase in health care trend or inflation and health care utilization by our members. Overall, Empire's historic MLR's for small group policies have been substantially higher than the 82% statutory minimum With the proposed rate adjustments, Empire's overall MLR is expected to remain above the 82% minimum allowable ratio. In the event Empire's MLR does not meet the required minimum, Empire will refund the difference to policyholders.

Empire has attempted to limit the rate increases to the lowest feasible level while preserving the financial integrity of the products. This rate action is intended to keep the rates at an adequate level to compensate for both anticipated utilization and the annual increases in the cost of medical care (*See description of health care costs below*).

Periodic rate adjustments are necessary to secure the ability of Empire, like any health insurer, to produce sufficient revenue and surplus for reserves to assure continued coverage and claim payments both for current healthcare needs and potential catastrophic cost situations. Empire's reserves vary from year to year based on actual healthcare costs incurred and typically vary from 3 to 6 months of foreseeable claims costs. Failing to meet the minimum statutory reserves will result in the insurer being deemed "impaired" under the New York Insurance Law. These reserves are the "insurance" that ensures 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.

In filing this rate application we are sensitive to the fact that businesses struggle to afford health insurance coverage and we are seeking the appropriate premium necessary, as determined by our actuaries, to maintain a viable health plan. In our sound actuarial judgment it is clear that an increase in premiums is critical to ensure the viability of these products. Failure to approve these rates will likely lead to even greater rate increases and fewer product offerings in the future as claim costs will eventually exceed premiums collected.

II. 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. Nationally, the growth in the cost of medical care continues to significantly outpace consumer inflation. Total medical cost for a typical American family of four increased 5.4% last year (2014/2013 data). The raw number annual increase of $1,185 is the largest recorded in the previous ten years. Nationally, hospital costs continue to rise, with an increase of 5.7% in inpatient care costs in 2014-2013, and

an increase of 8.0% in outpatient costs.[1] According to the Center for Medicare and Medicaid Services' (CMS) National Health Expenditure Projections for 2012-2022, health care spending is projected to grow at a national average rate of 5.8 % from 2012-2022, 1.0 % faster than expected average annual growth in the Gross Domestic Product (GDP).[2]

These trends reflect underlying changes in the demographics and health status of America's population. The aging population is driving some of the increase – as people age they typically utilize more health services. Between 2010 and 2050, the population aged 65 and older is expected to double, as the "baby boomer" population ages and life expectancy continues to rise[3]. As this population nears Medicare eligibility the proportion of the insured population at older ages increases, thus increasing average costs. Moreover, the country's general declining health and the increase in obesity and other health concerns, even at younger ages, forces average costs upward.

Hospital

Hospitals (inpatient and outpatient care) account for the largest share (45% to 55%) of the health care premium dollar in New York; a percentage that continues to grow. Factors driving this growth include increasing demand for care, rising costs to hospitals of the goods and services needed to provide care, growing intensity of care needs, and the shifting of costs of Medicaid and Medicare hospital reimbursement reductions to commercial insurers. As hospitals see higher and higher costs, and payments from Medicaid and Medicare do not keep pace, hospitals have demanded disproportionately higher and higher reimbursement from private insurers.

Nationally, according to a 2012 report by the American Hospital Association, increasing costs to hospitals for the goods and services purchased to provide care accounted for 63% of overall growth in spending on hospital care from 2006 to 2010, while rising demand for care accounted for 29% of the overall growth in spending during the same period[4]. The increase in labor costs is the most important single driver of spending growth for hospitals, accounting for about 35% of overall growth and more than half of the growth in the costs of purchased goods and services. CMS estimates total hospital spending to have grown by 4.9 % in 2012, compared with 4.3 % growth in 2011, and projects hospital spending growth of 4.7% for 2014, 5.6% in 2015, and to grow at 6.4% average annually thereafter from 2016 through 2022.

The increase in cost is also attributed to other factors including increased intensity of hospital care, i.e., hospitals are using more resources to care for each patient. Increased intensity can be attributed to a variety of factors, including sicker patients with more complex conditions.[5]

The increase in cost for hospital inpatient care in Empire's operating area continues to

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[1] 2014 Milliman Medical Index
[2] Center for Medicare & Medicaid Services, National Health Expenditures Projections for 2012-2022
[3] Center for Medicare & Medicaid Services, THE NEXT FOUR DECADES The Older Population in the United States: 2010 to 2050
[4] American Hospital Association, The Cost of Caring, June 2012
[5] See, American Hospital Association, The Cost of Caring, June 2012

surpass the rate for the rest of the country

Medical
Costs per member for medical professionals have experienced relatively moderate increases over the past year. In 2014, CMS projects physician and clinical services spending growth to be 7.1 %.[6]

Prescription Drugs
In recent years, drug cost increases have been tempered by the recent shift of some popular drugs to generic. However, with the recent approval and introduction of new expensive specialty medications, such as Sovaldi for the treatment of Hepatitis C, which currently costs $1,000 per pill and $84,000 to complete the 84 pill regimen, we expect the cost increase to return to higher levels over the coming years.

III. ADMINISTRATIVE SAVINGS

Recognizing the impact that rate increases will have on our customers, Empire attempts to mitigate their impact by controlling and, if possible, reducing selected administrative costs to offset increases that are necessary or beyond our control. Our corporate culture emphasizes Continuous Improvements in all areas of the company with a focus on administrative savings and improving member and customer services.

As a result of these efforts and other cost saving measures, our 2013 administrative costs were 5.9% of premium, excluding the amount paid to the State in premium taxes. While we continue to strive to judiciously reduce administrative costs further, we want to avoid sacrificing customer service, which we believe would be at risk by further cost reductions.

IV. HISTORICAL FACTORS

New York Health Care Cost
New York stands out as an especially costly state in which to purchase healthcare. New York City remains the second most expensive major metropolitan area in the country with respect to healthcare costs. A 2012 report by Milliman noted that the cost of care to be 118.4% of the national average.[7] New York's dubious distinction as a high cost state is also borne out in Dartmouth Atlas data which shows the State outpacing national average costs in a wide variety of indicators.[8] As a ratio to national average cost, New York State registered 1.15 in overall Medicaid reimbursements; 1.31 in professional and laboratory reimbursements; and 1.37 in short stay inpatient reimbursements.

The cost per inpatient discharge is another indicator of News York's disproportionately high costs when compared to other states. . In New York, the cost per inpatient discharge

[6] Center for Medicare & Medicaid Services, National Health Expenditures Projections for 2012-2022
[7] See, 2010 Milliman Medical Index and 2009 Milliman Medical Index
[8] See, Dartmouth Atlas of Health Care, last accessed 9/13/2012

has increased from $9,178 in 2006 to $10,792 in 2012. In 2012, New York's cost per inpatient discharge continues to exceed the national median value of $9,843.[9] In addition, while hospital inpatient days have declined, hospital outpatient visits continue to grow and exceed the national average. In 2011, New York has 2,777 hospital outpatient visits per 1,000 individuals, which is 31% higher than the national average.[10]

New York's continued high length of stay (days) is another contributing factor to escalating cost. In 2012, New York's length of stay (days) averaged 5.1, exceeding the national median value of 4.5.[11] In 2010, hospital medical readmission rates are .1% to 2.0% higher than the national average, depending on the region, with the Bronx having the highest regional rates for 30-day medical readmissions in the nation, at 18.1%.[12]

In addition, New York continues to rank poorly on healthcare price transparency, which is recognized as a key component to reducing healthcare costs. In 2014, New York again received an F grade on health care price transparency laws from Catalyst for Payment Reform.[13]

State and Federal Taxes

New York adds more insurance taxes and assessments than any other state in the country. These consist of both direct taxes and a number of indirect taxes amounting to a total of over $4.1 billion in taxes passed on to New York healthcare customers in the form of higher premiums. These taxes include:

- NYS Premium Tax – this 1.75% tax is on all HMO and insurance contracts (and there is an additional amount for customers in the Metropolitan Transit Authority service area). For 2013, the combined entities of Empire incurred $79.4 million in premium taxes.
- Covered Lives Assessment – this indirect tax is a charge on all fully and self insured "covered lives" The purpose of the Covered Lives Assessment is to raise funds for a variety of state programs and for the state budget. The Assessment is included in claims costs for purposes of calculating the MLR. This assessment is currently a charge of from $0.71 to $16.47 per individual contract per month and from $2.35 to $54.37 per family contract per month. For 2013, the combined entities of Empire incurred $76.5 million in covered lives assessment fees.
- HCRA Surcharge – this is a 9.63% surcharge on all hospital discharges. The purpose of the HCRA Surcharge is to raise funds for a variety of state programs and for the state budget. The Assessment is included in claims costs for purposes of calculating the MLR. For 2013, the combined entities of Empire incurred $176.4 million in HCRA Surcharges.
- NYS Insurance Department "332" Assessment – while this assessment is appropriately intended to fund the cost of the Department's regulatory activities, there is an indirect tax whereby a large portion of the revenue generated by the

[9] 2014, Optum, Almanac of Hospital Financial and Operating Indicators
[10] The Kaiser Family Foundation State Health Facts. AHA Annual Survey
[11] See, 2014, Optum, Almanac of Hospital Financial and Operating Indicators
[12] See, Robert Wood Johnson Foundation, "The Revolving Door: A Report on U.S. Hospital Readmissions," February 2013.
[13] Catalyst for Payment Reform and the Health Care Incentives Improvement Institute, "Report Card on State Price Transparency Laws," March 2014.

assessment is used to fund other programs not directly related to insurance regulation. This assessment is charged to insurers based on the number of New York insured members they cover. For 2013, combined entities of Empire incurred $36.8 million in 332 assessment fees.

- ACA related taxes and fees, are projected to be $48.5 million and $51.4 million for 2014 and 2015, respectively, for Empire's HMO and insurer..

While there were not any new tax increases which contributed to the rates being increased with this application, each of these current taxes contribute significantly to the cost of coverage and will vary from year to year as the number of covered lives increases or decreases and the number of hospital discharges vary.

V. DETAILS OF THE PROPOSED RATE INCREASE

Empire provides health insurance protection to approximately 3.5 million persons in 28 counties in eastern and southeastern New York State. The proposed premium rates affect approximately:

- 13,000 small group HMO members; including 8,000 Healthy New York members
- 2,000 small group EPO members

Premium rates for community-rated customers are regulated by the Superintendent of Financial Services pursuant to Section 4308 or 3231 of the Insurance Law. The following tables show proposed annual rate changes for the indicated community rated products:

Plan Name	Requested Increase
Empire Essential Guided Access Plus EPO with H.S.A (gbcb)	21.7%
Empire Essential Guided Access Plus EPO Stepped (gwoa)	25.0%
Empire Essential Guided Access Plus EPO Stepped (gwoa)	25.0%
Empire Core Guided Access Plus EPO with H.S.A. (gugb)	21.7%
Empire Core Guided Access Plus EPO with H.S.A. (gwgb)	21.6%
Empire Preferred Guided Access Plus with HSA (ghab)	18.8%
Empire Healthy New York HMO	25.3%

VI. FINANCIAL DATA

Exhibit 1 contains the audited Statement of Financial Condition at December 31, 2013 for Empire HealthChoice Assurance, Inc. and Empire HealthChoice HMO, Inc.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company Empire HealthChoice HMO, Inc.
NAIC Code: 95433
SERFF Trac AWLP-129582437
Market Segment: Small Groups Off 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	$0.00	$552.47	$0.00	$0.00	$0.00
2015 Premium Rates	$0.00	$672.65	$0.00	$0.00	$0.00

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	20.3%

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	N/A	N/A	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	N/A	N/A	N/A

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	N/A	11.1%	11.3%
Expense Ratios	N/A	14.5%	16.3%
Pre Tax Profit Ratios	N/A	3.0%	3.0%

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