

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 qualified health plan community rate increases in 2015

Filed: on or about June 13, 2014

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 qualified health plans.

I. OVERVIEW

The rates being sought contain a zero percent operating margin for the health plan despite the health plan reporting operating losses in 2013 and a forecasted significant operating loss in 2014 based on first-quarter results. The proposed rate adjustment is based on the need to adjust prospectively from the state's reduction of rates by 6.3% on small group qualified health plans and by 4.0% on individual qualified health plans for 2014; an increasing medical cost trend; changes in the health insurance market driven by federal and state actions; and to adjust for an increased number of members migrating to lesser benefit coverage plans than had been forecasted. These changes are likely contributing factors for most upstate health plan reporting underwriting losses in the first quarter of 2014. Other contributing factors for the proposed 2015 rate adjustment include increases in fees, taxes and added coverage for new mandated benefits.

Excellus Health Plan and related companies ("EHP") provide health insurance and administrative services for about 1.8 million upstate New Yorkers in 39 counties. The proposed premium rates affect about 182,000 members or 10 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. The determination by the Department shall be supported by sound actuarial assumptions and methods.

The rate application will be filed with the Department on or about June 13, 2014. 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 2015 would, if approved, receive the indicated rate adjustments on their next anniversary date on or after January 1, 2015.

Excellus Health Plan is required by New York State law to develop rates that assume that at least 82% of premium revenue will be spent on health care costs in the direct pay market along with small groups, 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 other providers, the increase in health care trend or inflation and health care utilization by our members and approved premium. Excellus Health Plan's MLR has been and continues to exceed the statutory minimums. In 2013, the MLR for Excellus Health Plan was 94.2% for individual direct pay and 91.0% for small groups. Under new reporting requirements for 2014, the three-year cumulative MLR is 94.4% for individual direct pay and 91.5% for small group qualified health plans. With the proposed rate adjustments, Excellus Health Plan's MLRs would remain well above the minimum levels. In the event the MLR falls below the required minimum, the health plan refunds any difference to policyholders.

EHP exceeded state and federal standards by \$87 million in the amount it spent on medical benefits for members in its small group and individual plans in 2013. Using the new reporting requirements for 2014, the three-year cumulative total would mean EHP exceeded state and federal standards by \$263 million in the amount it spent on medical benefits for its members in individual and small group plans for 2011-2013.

As explained further in this narrative, the requested rate increases are due primarily to the annual increases in the cost 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. It would also be unfair to subsidize community rates from other segments of business.

Periodic rate adjustments are necessary to secure the ability of Excellus Health Plan, or any insurer, to produce sufficient revenue and surplus for 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, 2013, the health plan had reserves equivalent to 2.5 months of claims and operating expense, and 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 a minimum level of reserves or a minimum risk-based capital ratio is not a sound financial practice for any health plan. The health plan also does not seek to accumulate industry benchmark levels of reserves or reach top risk-based capital scores that have been achieved by some health plans. The community rate increases proposed are designed to achieve a zero percent operating margin for the business to continue offering competitive and affordable access to health coverage in our communities. Our business, however, depends on not seeing financial losses either, so it can continue to provide participation in safety net products.

In filing its rate application, Excellus Health Plan is sensitive to the fact that individuals and small businesses struggle to afford higher premiums. However, 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 as claim costs would 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.

"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 Segal Consulting and Buck Consultants are forecasting a 7.2-10.4% medical benefit trend nationwide for 2014. EHP is forecasting an overall medical benefit trend factor for its commercial fully insured business of 6.8 % for 2014-2015. 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, 6.9%
- Hospital outpatient, 6.4%

- Professional services, 4.5%
- Pharmacy, 10.6%
- Other medical goods and services, 7.5%

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.

A note about the 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 2013 and the number of services provided was 100, the total amount spent in 2013 related to that service would be \$10,000. If the price of the service rose 10 percent in 2013 and the number of identical services rendered rose 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 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 drug costs because professional services represents a larger share of medical benefit spending.

III. NEW YORK TAXES AND ASSESSMENTS

Insurance taxes are built into the costs of health coverage. New Yorkers who voluntarily purchase private health insurance coverage paid more than \$4 billion in state health taxes in 2011, according to an analysis by the New York State Conference of Blue Cross and Blue Shield Plans.

New York’s Health Care Reform Act of 1996 (“HCRA”) created two surcharges on health insurance and an additional tax is imposed under Section 206 (formerly Section 332) of the state Insurance Law.

The covered lives assessment is an annual flat surcharge or tax on every person who has insurance coverage in the state. Health plans are assessed on the basis of the number of people they cover with individual and family rates that vary depending on the residence of the insured. Among upstate regions defined by the state, the annual covered lives assessment rates in 2014 that impact Excellus Health Plan members are as follows:

	Per Certificate Per Year		Per Certificate Per Month	
	Individual	Family	Individual	Family
Western	\$39.40	\$130.03	\$3.28	\$10.84
Rochester	\$105.72	\$348.87	\$8.81	\$29.07

Central	\$55.59	\$183.46	\$4.63	\$15.29
Utica/Watertown	\$8.54	\$28.17	\$0.71	\$2.35
Northeastern	\$39.94	\$131.79	\$3.33	\$10.98

The second surcharge created by the 1996 Health Care Reform Act is collected from health plans in the form of a sales tax on many hospital-related services. The surcharge is applied to both self-insured and fully insured plans. Beginning at 8.18 percent in 1997, the surcharge is now at 9.63 percent.

The third levy, the Section 206 assessment, was originally established to finance New York State Department of Insurance operations but its funding purposes have expanded beyond that purpose. The assessments apply to all licensed insurers in the state (e.g. life, property and casualty, and health), and are based on New York premiums.

In total, the above New York taxes and assessments including Section 206 aggregated to nearly 6% of the 2015 small group and individual qualified health plans' premium.

IV. FEDERAL TAXES, MANDATES AND ADJUSTMENTS

Annual fee on health insurance providers:

Beginning in 2014, this fee is based on each health insurance company's market share of net premiums written, adjusted for size and corporate structure. The fee is assessed on all fully insured health plans, individuals purchasing coverage on their own, Medicare beneficiaries enrolled in a Medicare Advantage plan or a prescription drug plan and states that contract with health plans for Medicaid.

The federal law requires the total fee on nationwide health insurance providers to be collected is:

- \$8 billion in 2014,
- \$11.3 billion in 2015 and 2016,
- \$13.9 billion in 2017, and
- \$14.3 billion in 2018.
- After 2018, the fee is expected to collect \$14.3 billion, indexed to the rate of growth in premiums. Each year, the calculation will be based on the market share of each assessed plan and will change based on the number of companies in the insured market. Under this fee provision, a health plan could incur financial losses but would still be subject to the market share fee.

For EHP, this fee increase represents a 1.2% increase to current premium for small group and individual qualified health plans for 2015.

Risk Adjustment Program:

The risk adjustment program is a permanent provision that applies to both the individual and small group insurance market. 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.

A fee of \$0.96 per member per year is collected to fund the risk adjustment program. For EHP, this program reduces small group qualified health plans' premiums by about 1.5%. For 2015, this program has no impact on the premium of individual direct pay qualified health plans.

Transitional reinsurance program for the individual market:

The federal law created a temporary reinsurance program that is to collect nationwide:

- \$10 billion in 2014,
- \$6 billion in 2015, and
- \$4 billion in 2016.
- Additionally, a separate contribution is to be deposited into the U.S. Treasury that will total \$2 billion in 2014, \$2 billion in 2015, and \$1 billion in 2016.

The contribution rate is to be based on a \$44 national per capita yearly amount in 2015. All insurers and self-insured group health plans are required to contribute on behalf of all group health plans and health insurance coverage they provide. For EHP, this fee represents about 1% of premium but it is about 40% less than last year resulting in a 0.5% decrease to current premium for small group and individual qualified health plans in 2015.

For the individual qualified health plans, the federal government established reinsurance for excessive claims. The amount of money being distributed in 2014 is being reduced in 2015. At the same time, this reduction will require a 3.8% premium increase for individual qualified health plans.

Patient Centered Outcomes Research Institute ("PCORI") fee:

The federal law created the PCORI to help stakeholders make informed health decisions by advancing the quality and relevance of evidence-based medicine through the use of comparative clinical effectiveness research findings. The fee is set at \$2 per year multiplied by the average number of lives covered under the plan for plan years ending before October 1, 2014. And, for plan years ending on or after October 1, 2014, the fee increases based on the projected per capita amount of National Health Expenditures.

Federal mental health mandate

The federal requirements for coverage of mental health parity require a 0.2% increase to current premium to pay for required benefits in 2015.

V. 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.

The proposed rates will more accurately reflect the true operating expense of administering the federal Health Care Reform legislation through the state's on-line exchange. The changes in the health insurance market required building and implementing an entirely new sales channel from what had primarily been a business-to-business marketplace. This required:

- The implementation of a new sales call center that saw extended open enrollment deadlines in 2014;
- The hiring of additional staff;
- Increased direct-to-consumer communication costs to educate consumers about new products and how to access those products; and
- The building and implementation of new products, new infrastructure for the continued improvements and changes to the state's on-line exchange and for the implementation of additional mandates for the federal Health Care Reform.

Operating expenses - including quality improvement initiatives but excluding federal and state taxes, fees and assessments, and broker commissions - represent 8.7% of premium in small group qualified health plans and 8.4% in individual qualified health plans.

VI. REGULATION 146

Regulation 146 was a market stabilization mechanism for the individual and small group pools that was in effect prior to the adoption of the ACA. Similar to the ACA Risk Adjustment program, Reg. 146 attempted to equalize the risk within the small group and individual markets by assessing a charge on health plans that have low-risk members and used this revenue to compensate plans with higher risk members. Because of the redundancy with the new risk adjustment program, Reg. 146 is being phased out. The Department of Financial Services is requiring plans to distribute all outstanding compensations through premium adjustments in 2015 and 2016. This distribution plan results in a reduction in the small group qualified health plan premium of 0.3% and in individual premium of about 1%.

EXHIBIT 13: NARRATIVE SUMMARY AND NUMERICAL SUMMARY

Company Excelsus Health Plan, Inc.
NAIC Code: 55107
SERFF Tra EXHP-129573829
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 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	574.32	477.93	409.82	325.32	N/A
2015 Premium Rates	665.59	555.56	477.77	381.34	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	16.4%

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	11.2%	12.4%	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	0.90	0.90	0.90

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	6.68%	7.40%
Expense Ratios	N/A	0.155	0.172
Pre Tax Profit Ratios	N/A	1.00%	0.00

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