

7/18/2014  
APPLICATION TO THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES  
FOR A PREMIUM ADJUSTMENT

NAIC #: 55204  
SERFF Tracking #: HLTH-129631424

TO BE EFFECTIVE UPON 2015 RENEWAL DATE

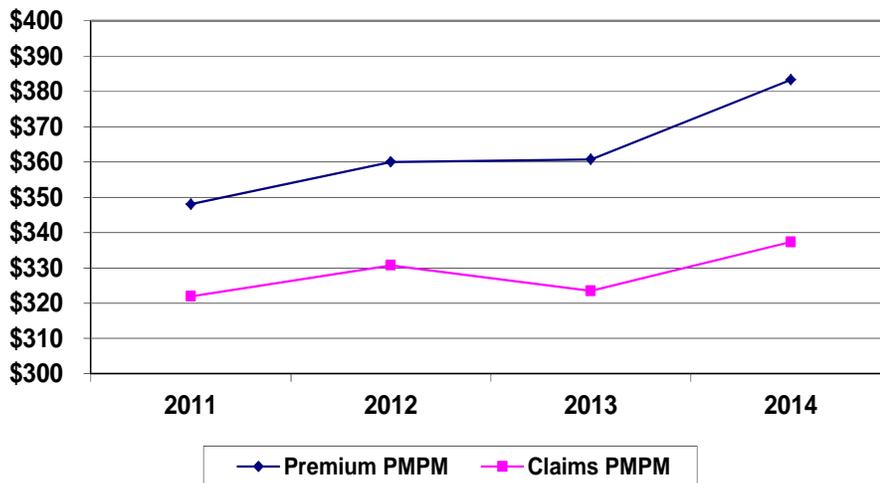
THIS APPLICATION IS FOR LARGE GROUP COMMUNITY-RATED PRODUCTS

**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).

**History of Increases**



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 7 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 large, community-rated group products (51+ 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 18,000 members will be affected by the rate change.

Our large group community-rated products are offered in the following regions within the listed counties:

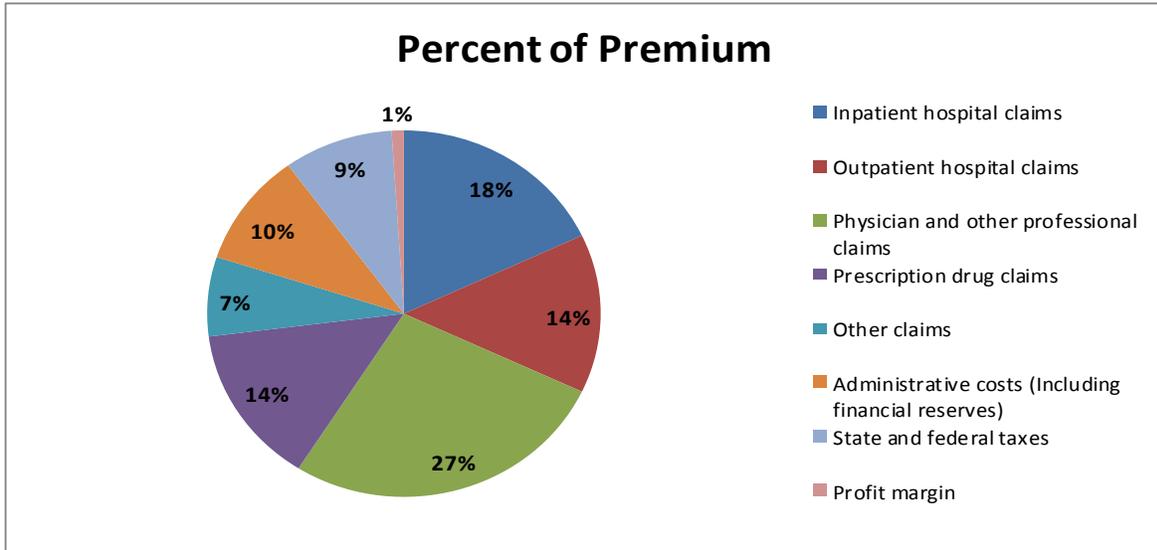
**Buffalo Area:** Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

**Albany Area:** Albany, Columbia, Clinton, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington

Any specific product we offer may be available only within a subset of our rating regions

### 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 <sup>1</sup>	2015 <sup>2</sup>
Inpatient hospital	-2.5%	0.6%
Outpatient hospital	0.3%	1.3%
Physician / professional	-0.2%	0.6%
Prescription drug	-3.5%	-3.6%

**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	6.3%	2.6%
Outpatient hospital	5.7%	3.7%
Physician / professional	0.8%	1.4%
Prescription drug	9.4%	8.3%

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<sup>1</sup> The current year is not yet concluded so our data at the time of this application is a projection for all 2014 statistics.

<sup>2</sup> 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 large group community-rated products as follows:

Leveraging	2014	2015
Large Group	0.1%	0.1%

**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 large group community-rated products as follows:

Medical Demographic Shift	2014	2015
Large Group	-1.5%	0.8%

Prescription Drug Demographic Shift	2014	2015
Large Group	-0.3%	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 large group community-rated products) are as follows:

Administrative Costs	2013	2014	2015
Large Group	\$48.54	\$45.23	\$46.79

## 5. 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 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 large 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.

In total, the ACA expenses account for approximately 4% of our large group community rated group premiums.

The combination of both the state health care taxes and the federal ACA fees constitutes approximately 9% of our community-rated premiums.

## 6. 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 large group community-rated business subject to this annual rate application is as follows:

Loss ratios	2013	2014	2015
Large Group	87%	91%	90%

**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
Large Group	4.1%	1.0%	1.0%

## 7. 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.

## **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 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.

- $(98 \times \$5 = \$490) + (2 \times \$55 = \$110) = \$600$  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.

- $(90 \times \$5 = \$450) + (2 \times \$55 = \$110) = \$560$  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> .

## 9. 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.

**Commercial Community-Rated Large Group 2015 Renewals:** These adjustments will affect large group policy holders on their anniversary dates in 2015. Total premium increases may be higher or lower, depending on the prescription drug option selected. Please see section 2 for a definition of each rating area.

### Buffalo Area

- The HMO 100 base medical plan has a proposed rate change of 5.5%
- The NYSHIP HMO base medical plan has a proposed rate change of 2.8%

### Albany Area

- The HMO 200 base medical plan has a proposed rate change of -5.2%
- The Traditional Indemnity base dental plan has a proposed rate change of 9.9%