



BlueCross BlueShield of Western New York  
257 West Genesee Street • Buffalo, New York 14202

APPLICATION BY BLUECROSS BLUESHIELD OF WESTERN NEW YORK  
TO THE NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES  
FOR A PREMIUM ADJUSTMENT

NAIC #: 55204  
SERFF Tracking #: HLTH-128847546

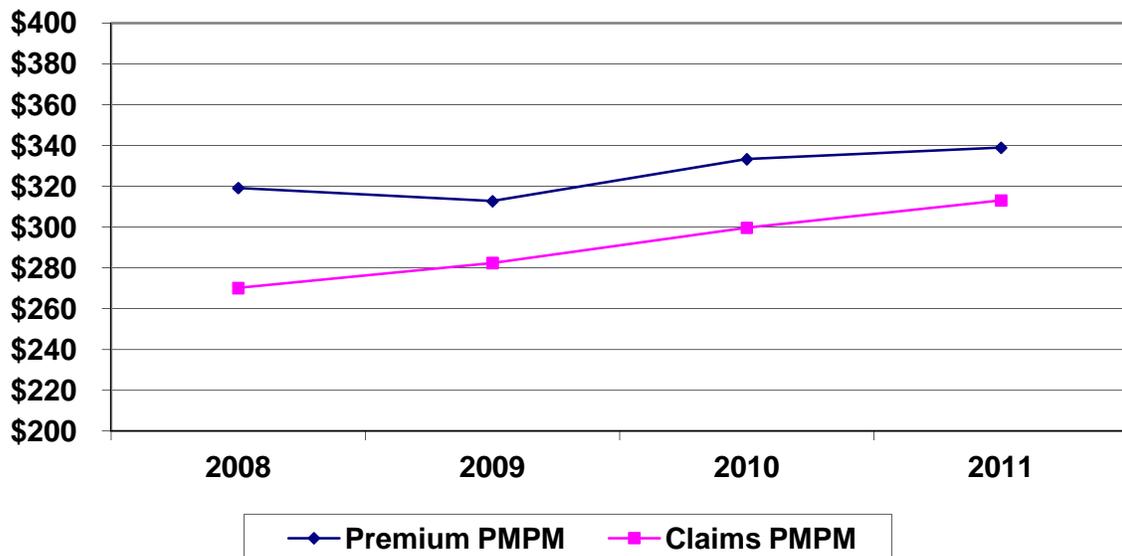
TO BE EFFECTIVE UPON 2013 RENEWAL DATE

THIS APPLICATION IS FOR OUR COMMUNITY RATED PRODUCTS

**1. Introduction.** BlueCross BlueShield of Western New York has submitted this application to modify premium rates. We are well aware of the difficulty that all businesses and individuals have in paying premiums. The trend of constantly rising health care costs has been going on for some time and, as a company that listens carefully to our customers, we are well aware of the financial problems and difficult choices that rising premiums cause in our customer's budgets. We did not submit this application lightly; we did so only after serious consideration of the impact of the increases, and only after implementing measures to reduce costs as much as possible.

Consistent with experience around the country, the annual rise in premium rates closely tracks the underlying annual rise in health care costs. The amounts that hospitals, doctors and others charge for their services rises each year, as does the number and intensity of services that are used by the people we insure. It logically follows that premiums will therefore rise as well. For example, the chart below demonstrates that premiums rise to follow the increasing per person costs of health care incurred by our community rated members. More information about those rising healthcare costs is listed below. We hope that review of the materials below will at least explain why the premium increases are occurring.

**History of Increases**



We have done our best to limit those underlying annual increases in health care costs. We have in place a number of programs designed to reduce medical waste and to help our members to better manage their health to avoid costly medical conditions (See section 7 below for more detail on these programs.). We have also negotiated vigorously with doctors, hospitals and other providers of care to limit their annual fee increases. However, we need to be cautious during those negotiations because it is important that those providers receive sufficient payments from us to assure they are ready, willing and able to provide the high quality care members expect when they seek care. We have also created alternative products which provide valuable coverage but at a lower price, such as our high deductible health plans.

## 2. Who is affected and when.

This rate change application affects only the customers enrolled in small group, sole proprietor, or direct pay products (as well as a few large group customers). All the customers and products subject to this application are community rated. This means that all members holding the same coverage have the same premium; the premiums do not vary by age, sex, medical conditions or usage of health care services.<sup>1</sup> Most large groups and government programs are subject to different premium setting rules and a different approval process than applies to this application.

For the small group, large group, and sole proprietor community rated groups, the rate change will be effective upon renewal date in the 3<sup>rd</sup> and 4<sup>th</sup> quarter of 2013. The rates vary by the 2013 calendar year quarter in which the group renews and are guaranteed for the 12 month period starting on the renewal date. Commercial community rated includes all HMO (100 series and 200 series), POS Lite (aka 250D), EPO (Sky), PPO 800 series, High Deductible (8000 series (aka Healthy Balance), 7000 series (POS 7000 is also called Slate) and POS / PPO Denim), Indemnity 900 series products, and Dental.

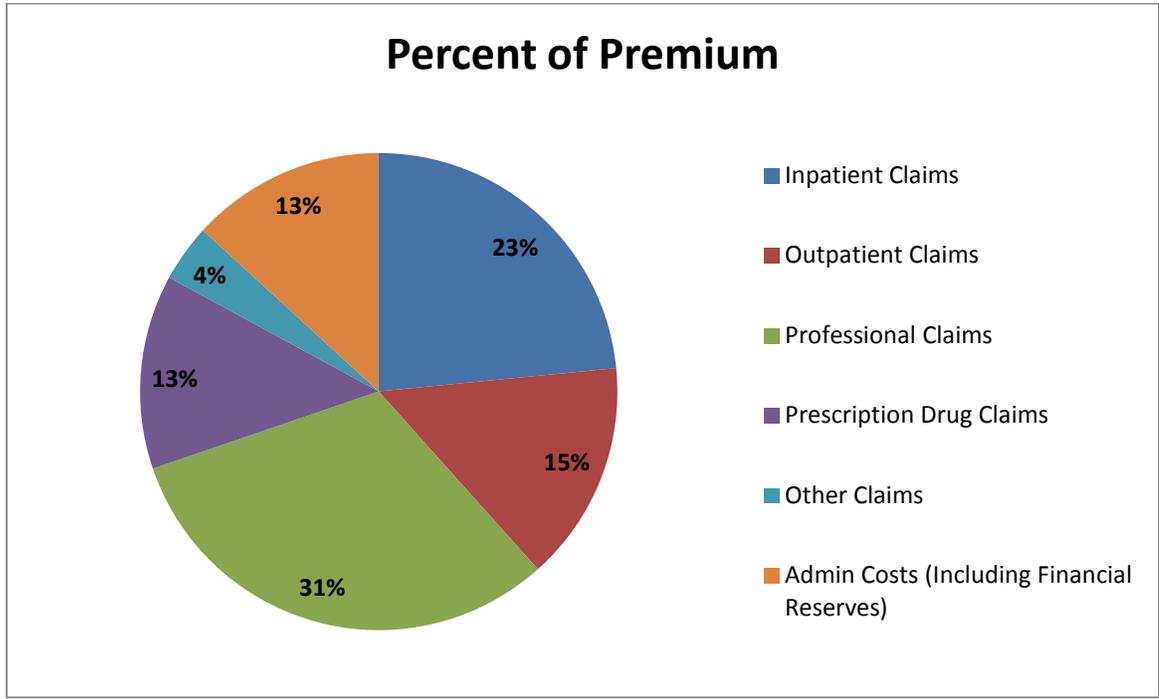
The estimated total number of members affected by the rate change based on current membership is 16,846.

## 3. Where premium dollars go.

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<sup>1</sup> Community rating is mandated by New York law for all insurers and HMOs for all direct payment customers and all small groups (including associations containing small groups).

The chart below shows the percent of premium represented by various 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' health care and we determine there is a pattern of rising costs. Below is a summary of the key factors in determining our premium rates, and why the rates need to 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 numbers of services used per 1,000 members to calculate usage rates. But, in addition, sometimes the nature of the care rendered becomes more extensive than it was the prior year. For example, if doctors use more complicated and expensive tests instead of less costly ones 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 increase in our region as follows:

Utilization Changes	2012 (Proj) <sup>2</sup>	2013
Inpatient Hospital utilization	3.6%	0.7%
Outpatient Hospital utilization	5.2%	2.9%
Professional utilization	4.0%	3.8%
Prescription Drug utilization	-1.4%	-2.6%

<sup>2</sup> The current year is not yet concluded so our data at the time of this application is a projection.

B. Price of services. These are unit prices charged by pharmaceutical companies, hospitals, doctors, and other providers of medical services. Despite our best efforts to negotiate to keep rates lower, we expect the following fee increases:

<u>Price Changes</u>	2012 (Proj)	2013
Inpatient Hospital prices	7.9%	6.5%
Outpatient Hospital prices	6.4%	6.0%
Professional prices	2.6%	1.8%
Prescription Drug prices	0.8%	1.9%

C. Copay/Deductible Leveraging. When the price of medical services increases, if a plan design has deductibles and copays that are fixed dollar amounts rather than a percent coinsurance, the costs to the insurer will increase at a higher rate. As an example, suppose the fee for a typical doctor's office visit is \$100 and the patient pays a \$25 copay. The cost to the insurer would then be \$75. Now suppose the next year the doctor's fees increase 5% to \$105 and the patient's copay is still \$25. This leaves \$80 for the insurer to pay, a 6.67% increase. This additional 1.67% increase above the 5% increase in fees is called leveraging. We expect this to impact the community rated products as follows:

<u>Leveraging</u>	2012 (Proj)	2013
Small/Large Group	1.2%	1.2%
Direct Pay	0.1%	0.1%
Healthy New York	1.1%	1.1%

D. Population Demographics. Different age and gender combinations tend to have different average costs to insure. At younger ages, women tend to cost more than men; at older ages, men tend to cost more than women; and older people tend to cost more than younger people. 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 age/gender combinations. We expect this to impact the community rated products as follows:

<u>Medical Demographic Shift</u>	2012 (Proj)	2013
Small/Large Group	2.1%	2.1%
Direct Pay	0.5%	0.0%
Healthy New York	4.0%	1.0%

<u>Prescription Drug Demographic Shift</u>	2012 (Proj)	2013
Small/Large Group	1.5%	1.5%
Direct Pay	-4.4%	0.0%
Healthy New York	7.0%	1.0%

E. Administrative costs. These are the costs to operate the insurer, including our costs for sales, customer service, processing and paying claims, reviewing utilization of care and the quality of care to assure claims payments are appropriate, detecting fraud and abuse, and maintaining our financial reserves so that we have sufficient funds to pay members' claims if

there is an unexpected rise in claims payments. The anticipated change in our per member per month administrative costs and financial reserves (as reflected in our premium rates) is as follows:

Market	2012 (Proj)	2013
Small/Large Group	\$41.55	\$42.79
Direct Pay	\$43.51	\$39.65
Healthy New York	\$40.25	\$27.40
Medicare Supplement	\$44.04	\$55.31

**5. State Healthcare Taxes & Assessments.** 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 \$13.9 million<sup>3</sup> on our community rated business during 2011.

B. An “assessment” on each person (life) we cover for persons residing in N.Y.S. The assessment is larger for family coverage than for single persons. The assessment varies by geographic region of N.Y.S. We paid approximately \$3.5 million<sup>3</sup> on our community rated business during 2011.

The surcharges and assessments are mandated by New York’s Health Care Reform Act (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. All insurers pay a fee to fund the operations of the New York Department of Financial Services (formerly the Insurance Department). Thus the State Department of Financial Services is funded by insurers rather than by state income or typical state taxes. We paid approximately \$4.6 million<sup>3</sup> on our community rated business during 2011.

The combination of all our payments of the State health care taxes above constitutes approximately 4% of our community rated premiums.

**6. Our Financial Information.**

We maintain financial reserves for the protection of our customers. These are monies we have 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 reach into our bank accounts in order to pay claims for our members in the event current premiums are not sufficient to pay current 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

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<sup>3</sup> This amount represents the entire Community Rated Commercial business of HealthNow New York Inc.

investment of these reserves in fixed income and other securities. As of December 31, 2011, our corporate reserves were 22.1% of annual premium. This was a \$39 million decline from December 31, 2010, when they were 23.7%.

There are a few financial measures that directly impact 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” (MLR).

Loss Ratios	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Small/Large Group	92%	91%	96%	87%
Direct Pay	105%	102%	110%	94%
Healthy New York	88%	96%	107%	90%
Med. Supp.	87%	85%	89%	82%

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 is as follows:

Gain/Loss	2011	2012 (Proj)	2013 (without increases)	2013 (with increases)
Small/Large Group	-4.6%	-1.4%	-6.8%	3.0%
Direct Pay	-21.7%	-13.0%	-23.6%	-6.1%
Healthy New York	-1.7%	-8.2%	-18.8%	0.3%
Med. Supp.	-19.7%	-10.0%	-13.1%	-4.4%

7. Our Cost Control and Quality Improvement Efforts. We have implemented several initiatives that are important to improving the health care of our members and assuring they receive the high quality medical care they deserve. These important initiatives include:

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:

- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Asthma
- Diabetes
- Back Pain

B. Coordination of Care. Comprehensive care management programs are designed to improve the health outcomes and satisfaction of our members through collaborative relationships with the members and our providers. We achieve our goals by enabling our members to make informed health care decisions and assisting them to navigate through the health care continuum. This assures appropriate quality care in a cost effective manner.

C. Hospital Readmission Reduction. Prior authorization processes ensure that the member having 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 would be medically necessary.

D. Improving Patient Safety and Reducing Medical Errors. Our Medical Economics staff provides analytics and information that allow us to contact members in order to manage their quality of care, ensure they do not get re-admitted into the hospital, or coordinate a plan of care with the member's physician.

E. The focus of the Quality Improvement Program is to continuously assess and improve the care delivered by our participating practitioners/providers.

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

G. Fraud detection. It is an unfortunate reality that some customers, and some providers of health care, submit claims for services that were not in fact delivered, or which were billed at amounts higher than they should be. Our dedicated fraud detection staff conducts audits of claims payments, and works with the State Department of Financial Services (formerly the Insurance Department) and local prosecutors.

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 fire 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.

For example, assume the product pool consists of 98 members with low health costs (\$5 each) and two persons with high costs (\$55 each), and thus total claims expenses of \$600.<sup>4</sup> That produces an average cost of \$6 per member. If 8 of the low cost members depart to buy other coverage or drop their insurance, there are now 90 members with low costs and two persons with high costs. The average cost rises to \$6.90 per member<sup>5</sup>. That is a 15% increase in premium due solely to the changed composition of our insurance pool. Then 10% or so is added to account for the rising price of prescriptions, hospitals etc., (see section 4 above) and thus the premium increase becomes 25%. The impact of this constant factor in premium setting is made much worse when rising health care costs, and a sluggish economy, cause more people than usual to drop their coverage, or seek other, lower cost products.

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

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

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<sup>4</sup>  $(98 * 5 = 490) + (2 * 55 = 110) = \$600$  total. Divided by 100 members = \$6 per member.

<sup>5</sup>  $(90 * 5 = 450) + (2 * 55 = 110) = \$560$  total. Divided by 92 members = \$6.90 per member. \$6.90 is 15% more than \$6.00.

The remaining page(s) show the rate changes requested by region, product, and group size in the rate filing. For Community Rated groups, the rate change is dependent upon anniversary date which is identified at the top of each page.

# Proposed Rate Adjustments

## Buffalo – Small Group

- The Aqua base medical plan has a proposed rate change of 17.0%
- The HMO 100 base medical plan has a proposed rate change of 18.0%
- The POS 7000-series base medical plan has a proposed rate change of 17.0%
- The PPO 7000-series base medical plan has a proposed rate change of 17.0%
- The POS 8000-series base medical plan has a proposed rate change of 17.0%
- The PPO 8000-series base medical plan has a proposed rate change of 17.0%
- The POS 250D Select base medical plan has a proposed rate change of 17.0%
- The Traditional Indemnity base medical plan has a proposed rate change of -5.0%