

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 2020

Filed: on or about May 13, 2019

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 sought in this application are calculated to maximize benefits for our members by exceeding state standards in paying the rising costs and utilization of medical care, cover numerous federal and state mandated taxes and fees, and achieve a margin of 2 percent for our small group business and 1.5 percent for our individual business. The proposed rate adjustment for 2020 is negatively affected by the return of the federal health insurer fee that was suspended for 2019 rates. This fee, which supports the federal Affordable Care Act, represents 2.4 percent of 2020 premium dollars for both small group and individual business. Excellus Health Plan paid approximately \$112 million toward this fee in 2018. Other federal and state taxes and fees that impact our overall expenses amount to about \$383 million.

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 205,000 members or 13.3 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 13, 2019. The actual rate adjustments 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 2020 would, if approved, receive the indicated rate adjustments on their next anniversary date on or after January 1, 2020.

Excellus Health Plan is required by New York State law to develop rates that assume at least 82 percent 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 exceeded and continues to exceed the statutory minimums. Under current reporting requirements, the three-year cumulative MLR for the combined individual direct pay and small group plans is expected to exceed 90 percent. 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 typically due 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. For 2019, the requested rate increase for individual was about one-third of the state average for increase and for small group about half of the state average increase.

Periodic rate adjustments are necessary to secure the ability of Excellus Health Plan, or any insurer, to produce sufficient revenue and reserves to ensure 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, 2018, the health plan had reserves equivalent to 84 days of claims and operating expense-- more than the minimum required by New York State law. These reserves are the "insurance" that ensures payment even when costs run higher than anticipated, or emergencies or disasters occur. Reserves 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 a premium operating margin of 2 percent for small group and 1.5 percent for individual. 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, Oliver Wyman, Wells Fargo and PwC Health Research Institute are forecasting a 6.0-7.9 percent medical benefit trend nationwide for 2019 in their National Trend Surveys. EHP is forecasting an overall claims trend factor for its small group business of 6.6 percent and 7.1 percent for individual business for 2018-2019. 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, small group: 6.8% / individual: 5.1%
- Hospital outpatient, small group: 8.3% / individual: 8.8%
- Professional services, small group: 2.7% / individual: 2.2%
- Pharmacy, small group: 8.2% / individual: 10.1%, including:
 - Specialty Rx, small group: 18.5% / individual: 18.2%
 - Diabetic Rx, small group: 7.8% / individual: 7.9%
- Other medical goods and services, small group: 6.3% / individual: 8.9%

Rising prices for patented drugs are having the fastest growing impact on medical spending trends. This is a well-documented national phenomenon. Substantial savings have been achieved over the years with broad acceptance of competitively manufactured generic medicines. However, that trend of bringing down costs for consumers is being eclipsed by another trend concerning the cost of brand drugs with

patent protection and no generic alternatives. According to a report issued by the Blue Cross Blue Shield Association, the category of drugs known as single-source drugs is rising at an average annual rate of 25 percent following a pattern that produced a 285 percent increase since 2010. With no controls over those prices, these medicines now make up about 63 percent of total drug spending even though they comprise less than 10 percent of total prescriptions filled.

In our experience, prescription drug spending represents about 25 percent of our health plan’s claims expense in the combined small group and individual market. Because of the escalating prices and use of medicines, it is having a disproportionately higher impact on overall claims spending. Said another way, if the prescription trend were the same as the average medical trend, the rate increase request would be approximately 1.5 percentage points less than what is proposed.

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 2019 and the number of services provided was 100, the total amount spent in 2019 related to that service would be \$10,000. If the price of the service increases 10 percent in 2020 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 trend factors forecasted for each of the benefit component takes into account that compounding effect. And, the impact that each trend has on 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. This 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, a decrease in anticipated payments into this program results in a decrease to small group plans' proposed premium rates of about 1.2 percent in 2020. For 2020, an increase in the anticipated receivable from the same program results in a decrease to the proposed premium rates for individual direct pay plans of 1.8 percent.

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, are 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 8.0 percent 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 representing 7.6 percent of small group and individual premium. In total, the New York taxes and assessments aggregate to 5.2 percent of the 2020 small group and individual plans' premium. Federal taxes represent 2.4 percent of the 2020 small group and individual plans' premium.

This rate adjustment request is being filed at a time of uncertainty given the risk of potential and unknown changes to the Affordable Care Act under discussion by the federal government. In 2018, Congress placed a one year suspension on the Health Insurance Provider Fee for the 2019 calendar year. Had the suspension been extended by the current administration, the average required 2020 rate increase would be 4.3 percent for community-rated small-group plans and 1.7 percent for individual plans.

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 6.8 percent for its community-rated small group plans, and 4.2 percent for its individual plans to take effect on January 1, 2020.

EXHIBIT 13a: NUMERICAL SUMMARY AND RATE INDICATION CALCULATION

NUMERICAL SUMMARY

Company	Excellus
NAIC Code:	55107
SERFF Tracking #:	EXHP-131918193
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 "2020 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 2019 and 2020 should be based on the DFS Membership Survey data as of 3/31/2019.
- 12 This exhibit must be submitted as an Excel file and as a PDF file.

A. Average 2019 and 2020 Premium Rates:

- 1 Weighted Average Monthly Base Premium Rates are as calculated in Row 32 of the appropriate columns in Exhibit 13c (Columns L-P for 2019 and Columns U-Y for 2020)
- 2 Premium Rates for 2020 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
2019 Weighted Average Base Premium Rates	\$ 840.52	\$ 722.43	\$ 596.42	\$ 434.92	\$ 232.17
2020 Weighted Average Base Premium Rates	\$ 867.62	\$ 745.91	\$ 625.63	\$ 454.39	\$ 242.01

B. Weighted Average Annual Percentage Requested Adjustments:

	2019 to 2020	2019 Weighted Average PMPM Rate All - Metals	2020 Weighted Average PMPM Rate All - Metals
Requested Rate Adjustment	4.16033%	\$ 526.81	\$ 548.72

From Cells Q-74 and Z-74 of Exhibit 13c

C. Weighted Average Annual Percentage Adjustments for each of the Past Two Years [If Applicable]*:

	2017 to 2018	2018 to 2019
Average Rate Adjustment Requested	4.4%	8.9%
Average Rate Adjustment Approved	4.2%	4.6%

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

	2016	2017	2018
MLR	83.7%	75.8%	79.4%

E. Claim Trend Rates and Average Ratios to Earned Premiums [Per Exhibit 19 for 2018-2020 and Comparable Exhibits for 2018] [If Applicable]*:

	2018	2019	2020
Annual Claim Trend Rates	6.6%	6.3%	7.1%
Expense Ratios	15.9%	12.6%	14.7%
Pre Tax Profit Ratios	2.0%	1.5%	1.5%

* If no products were offered in a particular year, indicate "N/A" in the applicable box.