Request of:

Excellus Health Plan, Inc. doing business as

- **Excellus BlueCross BlueShield**

To:

The Department of Financial Services of the State of New York

For approval of Large Group HMO community rate increases in 2020

Filed: on or about July 15, 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 Large Group HMO community-rated products.

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 2 percent margin for our 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 the community-rated large group 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 15,000 members or 0.9 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 July 15, 2019. 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 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 85 percent of premium revenue will be spent on health care costs in the large group market, 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 been and continues to exceed the statutory minimums. 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, the health plan will refund any difference to policyholders in the affected market.

As explained further in this narrative, the requested average rate increases are due primarily 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.

Periodic rate adjustments are necessary to secure the ability of Excellus Health Plan, or any insurer, to produce sufficient revenue and 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, 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 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.

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. EHP is forecasting an overall medical benefit trend factor for its large group HMO business of 7.7% for 2019-2020. 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, 6.1%
- Hospital outpatient, 12.6%
- Professional services, 3.3%
- Pharmacy, 7.3%, including:
    - Specialty Rx, 15.5%
- Other medical goods and services, 8.4%

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 having to do with the cost of brand drugs with patent protection and no generic alternatives. According to a report issued this year by the Blue Cross Blue Shield Association, this category of drugs known as single-source drugs is rising at an average annual rate of 25 percent following a pattern of seeing 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.

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 2019 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 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 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.

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.

EHP's operating expenses represent an average of 5.2 percent of premium for large group HMO 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 7.9 percent of large group HMO premium. In total, the New York taxes and assessments aggregate to 5.5 percent of the 2020 community-rated large group plans' premium. Federal taxes represent 2.4 percent of the 2020 large group HMO 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 8.0 percent for community-rated large group 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 10.7 percent for its community-rated large group plans to take effect on January 1, 2020. The increase is composed of the following: claims trend (6.9%), improved experience (-1.0%), Health Insurance Provider Fee (2.4%), other administrative costs (1.3%), mandated benefit changes to in vitro fertilization services and mental health, substance abuse, and autism related services (1.1%).

Additional changes are being applied that have no impact on the average rate adjustment for the pool but will have variable impacts to specific groups and plans. Nearly all groups will receive a premium rate adjustment under 13 percent with a minimum of 0.8 percent and a maximum of 15.7 percent.