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An Anthem Company

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REQUEST OF:

EMPIRE BLUE CROSS AND BLUE SHIELD

TO:

THE DEPARTMENT OF FINANCIAL SERVICES of the STATE OF NEW YORK

FOR APPROVAL OF COMMUNITY RATE CHANGES

Filed May 9, 2016

NARRATIVE SUMMARY
[DFS and policyholder – for public posting]

I. OVERVIEW

Empire Blue Cross and Blue Shield (Empire) has made an application to the Superintendent of Financial Services to adjust premium rates for health insurance available to small groups.

These groups' employees and their covered dependents are combined, by long standing New York law, in what is known as a community rated pool. All members enrolled in the pool plans are guaranteed issuance of coverage and each contract holder is charged the same premium rate as any other contract holder for the health insurance product they select regardless of health status, age, sex, or other demographic factors other than the region of the State where they reside and family type.

Beginning in 2016, in compliance with federal regulation, the small group community pool includes groups with up to 100 employees. Prior New York law defined small groups as those with one to 50 eligible employees.

All medical, hospital, pharmacy, and other covered care and necessary administrative costs are combined, by law, in the pool in order to determine appropriate premium rates. These premium rates must support sufficient, sustainable revenue and reserves for both current and future coverage costs related to community pool products on a stand-alone basis. Current approved rates for Empire's community pool products are inadequate for the rising costs incurred as provider charges continue to rise and utilization of services increases.

The products specifically impacted by rate increases at this time are the small group products sold by Empire HealthChoice Assurance, Inc., (Empire's insurance company; NAIC code number 55093) and Empire HealthChoice HMO, Inc. (Empire's HMO company; NAIC code number 95433). These rate adjustments impact policies offered off-exchange (e.g., outside of the New York State of Health Marketplace). The actual rate increases requested are provided below. Empire's proposed rates are subject to review and approval by the New York Department of Financial Services (the Department), with the determination by the Department supported by sound actuarial assumptions and methods. The rate applications were filed with the Department on May 9, 2016 (SERFF numbers: AWLP-130548228 for Empire HealthChoice Assurance, Inc and AWLP-130548279 for Empire HealthChoice HMO, Inc). The actual rate increases approved will be communicated to the impacted parties upon completion of the Department's review and are scheduled to be effective January 1, 2017 upon group renewal.

Empire is required by New York State law to develop rates that are actuarially sound, assume at least 82% of premium revenue will be spent on health care costs, cover all claim costs, and also contribute to claims reserves. The percent of premium attributable to claims is essentially how much of the premium dollar is used to pay claims and is referred to as the Medical Loss Ratio (MLR). The actual MLR may vary over time based

on changes in the amounts charged by hospitals, physicians, and other providers, as well as, the increase in health care trend or inflation and health care utilization by our members. Overall, Empire's historic MLR's for small group policies have been substantially higher than the 82% statutory minimum. With the proposed rate adjustments, Empire's overall MLR is expected to remain above the 82% minimum allowable ratio. In the event Empire's MLR does not meet the required minimum, Empire will refund the difference to groups.

Empire has attempted to limit the rate increases to the lowest feasible level while preserving the financial integrity of the products. This rate action is intended to keep the rates at an adequate level to compensate for both anticipated utilization and the annual increases in the cost of medical care (*See description of health care costs below*).

Periodic rate adjustments are necessary to secure the ability of Empire, like any health insurer, to produce sufficient revenue and surplus for reserves to assure continued coverage and claim payments both for current healthcare needs and potential catastrophic cost situations. Empire's reserves vary from year to year based on actual healthcare costs incurred. Failing to meet the minimum statutory reserves will result in the insurer being deemed "impaired" under the New York Insurance Law. These reserves are the "insurance" that ensures 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.

In filing this rate application we are sensitive to the fact that businesses struggle to afford health insurance coverage and we are seeking the appropriate premium necessary, as determined by our actuaries, to maintain a viable health plan. In our actuarial judgment it is clear that an increase in premiums is critical to ensure the viability of these products. Failure to approve these rates will likely lead to even greater rate increases and fewer product offerings in the future as claim costs will 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. Nationally, the growth in the cost of medical care continues to significantly outpace consumer inflation. Although health care spending growth has slowed in recent years, it is projected to grow faster than GDP over the next decade. A report by Price Waterhouse Coopers (PwC) projects health care costs to grow 6.5% in 2016.[1]

Health care cost and spending trends reflect underlying changes in the demographics and health status of America's population. The aging population is driving some of the increase – as people age they typically utilize more health services. Between 2010 and

[1] Price Waterhouse Coopers (PwC) Health Research Institute, "Medical cost trend: Behind the numbers 2016", June 2015

2050, the population aged 65 and older is expected to double, as the "baby boomer" population ages and life expectancy continues to rise[2]. As this population nears Medicare eligibility the proportion of the insured population at older ages increases, thus increasing average costs. Moreover, the country's general declining health and the increase in obesity and other health concerns, even at younger ages, forces average costs upward.

Hospital

Hospitals (inpatient and outpatient care) account for the largest share (45% to 55%) of the health care premium dollar in New York; a percentage that continues to grow. Factors driving this growth include increasing demand for care, rising costs to hospitals of the goods and services needed to provide care, growing intensity of care needs, and the shifting of costs of Medicaid and Medicare hospital reimbursement reductions to commercial insurers. As hospitals see higher and higher costs, and payments from Medicaid and Medicare do not keep pace, hospitals have demanded disproportionately higher and higher reimbursement from private insurers.

The increase in cost for hospital inpatient care in Empire's operating area continues to surpass the rate for the rest of the country.

Medical

Costs per member for medical professionals have experienced relatively moderate increases over the past year. In 2015, CMS projects physician and clinical services spending growth to be 5.5%, due to increased demand for services associated with the continuing coverage expansions and faster income growth.[3]

Prescription Drugs

The recent approval and introduction of new expensive specialty medications, such as Harvoni for the treatment of Hepatitis C, which currently costs $1,000 per pill and $94,500 to complete the 12-week course of treatment, has dramatically increased prescription drug cost. In fact, PwC estimates that the cost of specialty drug spending will quadruple by 2020[4]. While only 4% of the population uses specialty drugs, they currently account for 25% of total US drug spending.[5]

III. ADMINISTRATIVE SAVINGS

Recognizing the impact that rate increases will have on our customers, Empire attempts to mitigate their impact by controlling and, if possible, reducing selected administrative costs to offset increases that are necessary or beyond our control. Our corporate culture emphasizes continuous improvements in all areas of the company with a focus on administrative savings and improving member and customer services. While we continue

[2] Center for Medicare & Medicaid Services, THE NEXT FOUR DECADES The Older Population in the United States: 2010 to 2050

[3] Center for Medicare & Medicaid Services, National Health Expenditures Projections for 2012-2022

[4] See, PwC Health Research Institute, Medical cost trend: Behind the numbers 2015, June 2014

[5] *Ibid.*

to strive to judiciously reduce administrative costs further, we want to avoid sacrificing customer service, which we believe would be at risk by further cost reductions.

IV. HISTORICAL FACTORS

State and Federal Taxes

New York adds more insurance taxes and assessments than any other state in the country. These consist of both direct taxes and a number of indirect taxes amounting to a total of over $6.5 billion in taxes passed on to New York healthcare customers in the form of higher premiums. These taxes include:

- NYS Premium Tax – this 1.75% tax is on all HMO and insurance contracts (and there is an additional amount for customers in the Metropolitan Transit Authority service area).
- Covered Lives Assessment – this indirect tax is a charge on all fully and self-insured "covered lives". The purpose of the Covered Lives Assessment is to raise funds for a variety of state programs and for the state budget. The Assessment is included in claims costs for purposes of calculating the MLR. This assessment is currently a charge of from $3.25 to $10.72 per individual contract per month and from $16.90 to $55.78 per family contract per month.
- HCRA Surcharge – this is a 9.63% surcharge on all hospital discharges. The purpose of the HCRA Surcharge is to raise funds for a variety of state programs and for the state budget. The Assessment is included in claims costs for purposes of calculating the MLR.
- NYS Insurance Department "206" Assessment – while this assessment is appropriately intended to fund the cost of the Department's regulatory activities, there is an indirect tax whereby a large portion of the revenue generated by the assessment is used to fund other programs not directly related to insurance regulation. This assessment is charged to insurers based on their premium volume.

ACA related taxes and fees – these are various fees set forth in the ACA.

Each of these current taxes contribute significantly to the cost of coverage and will vary from year to year as the number of covered lives increases or decreases and the number of hospital discharges vary.

V. DETAILS OF THE PROPOSED RATE INCREASE

Empire provides health insurance protection to approximately 3.5 million persons in 28 counties in eastern and southeastern New York State. The proposed premium rates affect approximately:

- 4,700 small group HMO members; including 2,500 Healthy New York members
- 400 small group EPO members

Premium rates for community-rated customers are regulated by the Superintendent of Financial Services pursuant to Section 4308 or 3231 of the Insurance Law. The following tables show proposed annual rate changes for the indicated community rated products:

Plan Name:	Empire Silver Pathway EPO 1500/30%/6500	Empire Gold Pathway HMO 1250/10%/6000	Empire Gold Healthy New York Pathway HMO 600/0%/4000
1ST QUARTER 2017			
Region 1: Albany	-1.9%	-1.8%	-1.6%
Region 3: Mid-Hudson	-1.8%	-1.7%	-1.5%
Region 4: NYC	5.1%	5.2%	5.4%
Region 7: Upstate	6.4%	6.5%	6.7%
Region 8: Long Island	16.3%	16.4%	16.6%
2ND QUARTER 2017			
Region 1: Albany	-1.2%	-1.1%	-0.9%
Region 3: Mid-Hudson	-1.0%	-0.9%	-0.8%
Region 4: NYC	5.9%	6.0%	6.1%
Region 7: Upstate	7.2%	7.3%	7.4%
Region 8: Long Island	17.2%	17.3%	17.5%
3RD QUARTER 2017			
Region 1: Albany	-0.4%	-0.3%	-0.2%
Region 3: Mid-Hudson	-0.3%	-0.2%	-0.1%
Region 4: NYC	6.6%	6.7%	6.9%
Region 7: Upstate	8.0%	8.1%	8.2%
Region 8: Long Island	18.0%	18.1%	18.3%
4TH QUARTER 2017			
Region 1: Albany	0.3%	0.4%	0.5%
Region 3: Mid-Hudson	0.4%	0.5%	0.7%
Region 4: NYC	7.4%	7.5%	7.7%
Region 7: Upstate	8.8%	8.9%	9.0%
Region 8: Long Island	18.9%	19.0%	19.2%