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 2024

Filed: on or about July 1, 2023

NARRATIVE SUMMARY

Excellus Health Plan, Inc. (NAIC code number x4289) 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 mandated taxes and fees, and achieve a 2 percent margin for our business.

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 11,000 members or 0.7 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 1, 2023. 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 2024 would, if approved, receive the indicated rate adjustments on their next anniversary date on or after January 1, 2024.

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.

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.

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, 2022, the health plan had reserves equivalent to 100 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 6.9% for 2022-2023. 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, -2.0%
- Hospital outpatient, 12.2%
- Professional services, 4.2%
- Pharmacy, 8.9%, including:
  - Specialty Rx, 13.8%
- Other medical goods and services, 7.3%

Rising drugs prices are having the fastest growing impact on overall 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 rising cost and utilization of specialty medications including biologics. Every year more and more highly complex specialty medications are approved by the FDA to treat both rare and sometimes more common diseases. Specialty medications are used by approximately 2 percent of our members, but they account for more than 46 percent of total drug spend. Drug trend is a result of both increased utilization and increased unit cost.

Prescription drug spending represents about 20 percent of our health plan's claims expense in the large group HMO market.

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 2023 and the number of services provided was 100, the total amount spent in 2023 related to that service would be $10,000. If the price of the service increases 10 percent in 2024 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 5.1 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 5.6 percent of large group HMO premium.

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 of 8.2 percent for its community-rated large group plans to take effect on January 1, 2024. The increase is composed of the following: claims trend (3.9%), experience adjustment (2.2%), administrative costs (0.6%), and 2023 DFS rate action (1.5%).