Actors Fund ☙ African Services Committee ☙ Children's Defense Fund-New York
Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority
Young Invincibles

June 28, 2018

Maria T. Vullo, Superintendent
Troy Oechsner, Deputy Superintendent for Health
John Powell, Assistant Deputy Superintendent for Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: Requested Rate Changes – HIP/Emblem– Individual – 131476171

Dear Superintendent Vullo, Deputy Superintendent Oechsner, and Assistant Deputy Superintendent Powell:

Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. HCFANY believes that the public rate review process is a vital consumer protection and is grateful for the opportunity to submit comments on the rate requests submitted for 2019's individual plans. The comments below address concerns about the market as a whole before offering specific comments on HIP/Emblem's application.

I. Market-Wide Comments

A. Action is needed beyond the rate review process to stabilize New York's individual market.

HCFANY is concerned that New York's insurance companies have not successfully controlled costs in the individual market. This year, the carriers seek an average 24 percent rate increase for the 2019 individual market plans.[1] This is the fifth year in a row that the requests have been in the double-digits for the individual market (the previous four years of requests and approved rate changes can be seen in the chart below).

[1] New York State Department of Financial Services, "Proposed 2019 Health Insurance Premium Rates for Individual and Small Group Markets," June 1, 2018, https://www.dfs.ny.gov/about/press/pr1806011.htm.

Average Requested and Approved Premium Increases New York's Individual Market 2015-2018[2]			
	Request (Percent)	**Approved (Percent)**	Percent Change
2018	17.7	**14.5**	-18.1
2017	19.3	**16.6**	-13.9
2016	10.4	**7.09**	-31.8
2015	12.5	**5.7**	-54.4

Such large increases cause immense hardships for those New Yorkers who receive little or no financial assistance through the NY State of Health Marketplace. Fortunately, most people (59 percent) in the Marketplace do receive help through tax credits that are based on income and grow as prices increase.[3] As a result, many are insulated from rate increases. However, 41 percent of people who enrolled in qualified health plans last year received no assistance.[4] That means they bear the full brunt of any approved premium increases. HCFANY is concerned that approving rate increases so far above the rate of medical inflation will eventually result in enrollment declines and ultimately, an insurance "death spiral" that would catapult premiums beyond the reach of anyone ineligible for assistance.

HCFANY commends the Department for its past efforts to safeguard consumers by reducing the carriers' average rate increases substantially and urges it to do so again this year. HCFANY's recommendations for doing so, based on a close reading of the applications, are below. HCFANY additionally asks that the Department and other state leaders take more forceful action outside of the rate review process to stabilize the individual market. High premiums force New Yorkers to choose between healthcare and necessities like housing and food.[5] Those choices continue even after someone gains coverage as they make their monthly payments and then face increasing cost-sharing.[6] High premiums also contribute to disparities in well-being between white Americans and others. Adults who are black are much more likely to report an inability to afford basic necessities and health care than adults who are white.[7] Adults who are black or Hispanic are more likely to have had medical bills turned over to debt collectors than those who are white.[8]

[2] For 2018, see https://www.dfs.ny.gov/about/press/pr1708151.htm. For 2017, see https://www.dfs.ny.gov/about/press/pr1608051.htm. For 2016, see https://www.dfs.ny.gov/about/press/pr1507311.htm. For 2015, see https://www.dfs.ny.gov/about/press/pr1409041.htm.
[3] New York State of Health, 2018 Open Enrollment Report, May 2018, page 5, https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202018%20Open%20Enrollment%20Report_0.pdf.
[4] Ibid.
[5] NORC and the West Health Institute, "Americans' Views of Healthcare Costs, Coverage, and Policy," March 2018, page 2, http://s8637.pcdn.co/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf.
[6] NORC and the West Health Institute, page 8.
[7] Ibid.
[8] NORC and the West Health Institute, page 6.

The role of private insurance companies is to pool risk for large numbers of enrollees and negotiate and control prices on their behalves. This year, as in the past, the carriers' applications state that providers are so powerful that this process cannot take place. If this is true, New York should take steps to control prices in the individual market and ensure that people who purchase their own plans have affordable coverage options. Other states have been more successful in keeping prices down in the individual market. For example, Minnesota has implemented a reinsurance program that has resulted in substantial declines in its individual market rates (between 3 and 12 percent).[9] To control prices in the individual market, New York should consider the following strategies:

1. **Provide premium assistance to people who make above 200 percent of the federal poverty level.** Increased premium assistance would stabilize prices by increasing the size of the risk pool. The more enrollees insurers have, the more they can spread the costs of care across individuals. Ideally, premium assistance would be available to everyone based on income. Encouraging greater participation by some groups could particularly help stabilize the individual market without great cost.,. Young people, for example, have lower incomes and lower health risks than older people. This means they are more likely to gamble against buying health insurance when dealing with tight budgets. Providing assistance to them would attract more people into our individual market who are lower risk. Insurers would be able to lower costs benefitting many in the market, and young people would have financial security in the event of a health emergency.

2. **Create a drug utilization review board for commercial plans in the individual market similar to the review board that exists for Medicaid.** All of the carriers cite increasing pharmacy prices as a reason for premium increases. For example, HealthNow estimated that medical prices would only increase by 3 percent while pharmacy prices would increase by 9.5 percent. Since so many insurance companies report being outmatched by the pharmaceutical industry, the state should consider intervening. New York's Medicaid program has a Drug Utilization Review Board charged with reviewing clinical information and making recommendations to the Commissioner of Health on drug coverage.[10] The Board's meetings are public, it includes consumers, and the process for nominating members is transparent. Such a Board could ensure that consumers benefit from any rebates and could negotiate for lower pharmacy costs across the market.

3. **Consider a public option such as an Essential Plan Buy-In Program.** The state should allow more people to participate in the Essential Plan as an affordable alternative to the individual market. The Essential Plan provides comprehensive coverage to people who earn between 138 and 200 percent of the federal poverty level.[11] Participants at the highest

[9] Minnesota Commerce Department, "Health insurers propose decreased average rates for Minnesota's 2019 individual market," June 15, 2018, https://mn.gov/commerce/media/news/?id=342571 .
[10] New York Department of Health, Office of Health Insurance Programs, "Medicaid Drug Utilization Review Board General Operating Procedures," https://www.health.ny.gov/health_care/medicaid/program/dur/docs/operating_procedures.pdf.
[11] Empire Center, "A surprising surplus in Albany," February 14, 2018, https://www.empirecenter.org/publications/a-surprising-surplus-in-albany/.

income level pay only $20 a month; the cost of their care to the state is minimal because most funding comes from the federal government.[12] New York could allow people with higher incomes to participate in the Essential Plan and offer state subsidies on a sliding scale. At a minimum the state could allow people to pay full-price to participate in the Essential Plan.

Other states have adopted additional measures that may be worth considering, such as the state-based individual coverage mandates recently adopted by New Jersey and Vermont.[13] Massachusetts has also had an individual mandate in place since 2006.[14] Alternately, New York could seek a 1332 Waiver to establish a reinsurance program along the lines of Minnesota or Alaska.[15] Finally, New York should seriously consider stepping in for the plans and controlling costs more directly through a Maryland-style global payment model.[16] All of these ideas—and more—bear scrutiny in the face of the carriers' substantial and persistent rate requests and HCFANY urges the Department to establish an Advisory Commission to explore them.

B. Within the rate review process, there are several areas in which we respectfully ask DFS to question insurers' arguments and impose greater standardization in their requests.

It is evident that federal activity has had a modest impact on New York's individual market. However, New York State has taken important steps to protect companies from those actions. Those steps included increasing the budget for enrollment assistors in the 2019 budget and opting to maintain the three-month open enrollment period. Additionally, under New York's strict laws, the carriers face little threat from the federal liberalization of rules governing association health plans.

As a result of the state's actions and an improved economy, New York's individual market appears to be stable—not contracting as some carriers claim. The New York State of Heath boasted an overall increase of 4 percent in 2018 enrollment.[17] Although New York's individual off-exchange marketplace lost enrollment, that appears mostly to be a self-inflicted wound imposed by the actions of one carrier (Empire) which terminated its entire line of

[12] Ibid.
[13] Katie Jennings, "New Jersey will become second state to enact individual health insurance mandate," *Politico New Jersey*, May 30, 2018, https://www.politico.com/states/new-jersey/story/2018/05/30/new-jersey-becomes-second-state-to-adopt-individual-health-insurance-mandate-442183.
[14] Ibid.
[15] Cheryl Fish-Parcham, "Alaska's Reinsurance 1332 Waiver: An Approach that Can Work, *Families USA*, August 2017, http://familiesusa.org/product/alaska-reinsurance-1332-waiver-approach-can-work and 2017 Minnesota Session Laws, Chapter 13—H.F.No.5, https://www.revisor.mn.gov/laws/?year=2017&type=0&doctype=Chapter&id=13.
[16] Shah et al., "Maryland's Global Budget Program: Still an Option for Containing Costs," *The Commonwealth Fund*, April 3, 2018, https://www.commonwealthfund.org/blog/2018/marylands-global-budget-program-still-option-containing-costs.
[17] Burton et al., "What Explains 2018's Marketplace Enrollment Rates?," *Robert Wood Johnson Foundation*, June 2018, https://www.urban.org/research/publication/what-explains-2018s-marketplace-enrollment-rates.

individual market products, causing disruption and panic amongst its 50,000 members.[18] In addition, more New Yorkers may be securing job-based coverage as the economy has improved. Despite these two trends, with a few minor exceptions, nearly all the other plans gained members between 2017 and 2018.

These conditions may not be adequately reflected in the 2019 rate requests. Thus, HCFANY urges the Department to carefully review the carriers' filings in a manner that ensures consistency of rate actions in the following areas: (1) the individual mandate; (2) trend; and (3) administration costs.

1. **Increases due to the loss of the mandate should be reasonable and companies with similar risk profiles should receive similar increases.**

In 2019, the federal tax penalty for failure to purchase health insurance will be eliminated. The carriers' applications contained varied estimates of the impact of this change with adjustments ranging from 0 percent to 23 percent. It is plausible that the variation of estimates is due to a carrier's claims experience and premium levels (which make the plan more or less likely to be attractive to someone on the fence about buying a plan). However, this explanation for the diversity of estimates is belied by the fact that carriers with apparently similar risk profiles are asking for vastly different increases. For example, Oscar and Fidelis have similar average claims costs, yet Fidelis asks for a 23 percent increase to make up for losing the mandate while Oscar asks for just 7 percent.

To ensure that all New Yorkers in the individual market are treated fairly and equitably, the Department should consider imposing a cap on the individual adjustment mandate—such as six percent, which is the average across all carriers. Those carriers that filed adjustments below six percent should be granted the adjustments that they seek (e.g. zero to six percent) and everything above would be reduced to six percent.

2. **Medical trend estimates vary too much. The state should require a standardized trend, either for the entire state or for regions.**

The carriers estimate medical trend between 5.1 and 11.5 percent. While most of the trend requests are within the ranges seen in national estimates (between 4.5 and 8 percent), there are reasons to think that New York's insurers could do a better job of managing these costs.[19] For example, many of New York's plans only offer in-network coverage and those networks are

[18] Empire's 2017 Rate Filing indicates that it had 54,000 members, while its 2019 filings now indicate that it has just 24,000 enrollees. In the interim, Empire retired its individual market offerings and re-filed a new product that was 47 percent more expensive than its predecessor.

[19] American Academy of Actuaries, "Drivers of 2019 Health Insurance Premium Changes," June 2018, http://www.actuary.org/files/publications/Premium_Drivers_2019_061318.pdf; Girod et al., "2018 Milliman Medical Index, May 2018, http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf; and PwC Health Research Institute, "Medical Cost Trend: Behind the numbers 2019," June 2018, https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pdf/hri-behind-the-numbers-2019.pdf

increasingly small.[20] Most estimates of annual medical trend changes are based on information from the employer market, where networks and benefits are often more expansive. That could be a reason to believe that medical trend should be lower for New York's narrow network plans.

Additionally, it is unclear why carriers in the same state and even in the same regions of the state should report such variation in medical trend. Each year, HCFANY notes in our rate review comments that the carriers do not provide enough information about how they arrive at their trend estimates. While the applications have improved in some ways over the years (for example, fewer redactions), not enough applications include a breakdown of trend into pharmacy versus medical costs. When they do, the carriers rarely provide a narrative explanation of how they manage costs, other than to argue that provider consolidation means they cannot reduce medical spend.

As an intermediate step, the Department should consider requiring carriers to provide better information about their trend estimates. The most helpful way for carriers to provide this information is through a trend breakdown showing the following: inpatient facility care, outpatient facility care, professional services, pharmacy, and other. This is helpful because it is the way that the Milliman Medical Index is reported, which provides a comparison point.[21] Some carriers did provide that information, including Excellus, Healthfirst, and Independent Health. Additionally, if all carriers provided this information the public would be able to compare their own insurer's performance to a statewide or regional average. HCFANY recommends that either Exhibit 18 or 13a be modified to require this information, or that the Department creates a new exhibit that shows a detailed trend breakdown.

More importantly, the Department should consider adopting a standardized medical and pharmacy trend cap for individual market carriers and requiring them to stay under the state limit. This measure could be implemented on a statewide or regional basis.

3. **Administrative costs should be decreasing over time. The Department should consider imposing a cap to guard against extraordinary administrative costs.**

Overall plans are asking for slightly lower administrative costs this year (12.1 percent versus 13.9 percent in their requests for 2018). But plans have had six years of experience operating in this market. New York State invests significant resources into marketing qualified health plans and making it easy for people to enroll and renew. The Department should investigate why administrative costs have not decreased more, and closely question plans whose administrative costs are increasing.

The range of administrative costs in the 2019 requests is also very wide, from 8.2 percent to 17 percent. Companies that spend much more of their premium dollars on administrative costs than peers should explain their performance in a detailed manner. Above-average rate increases from companies that also have above-average administrative costs deserve special scrutiny. The

[20] University of Pennsylvania/Robert Wood Johnson Foundation, "State Variation in Narrow Networks on the ACA Marketplaces," August 2015, http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf
[21] Girod et al.

Department should also consider imposing a cap on administrative costs that are far above average.

II. Issues Specific to HIP/Emblem

For the 2019 plan year HIP, which operates under the name Emblem, requests a 31.5 percent increase for their individual rates. This request is nearly double the average requested rate increase across plans and higher than HIP has requested in the last two plan years.[22] The explanations in HIP's Narrative Summary and Actuarial Memorandum to not adequately explain such a large increase. Likewise, HIP/Emblem fails to reconcile its projected jump in enrollment from 17,000 to 22,000 with its large rate request.

Accordingly, HCFANY urges the Department to carefully scrutinize HIP's 2019 rate application with special attention to the issues raised below.

A. HIP's proposed rate increase is so large that implementing such an increase would likely increase its losses rather than reduce them.

HIP unrealistically projects a 23 percent increase in membership, despite its proposed 31.5 percent rate increase. This is unrealistic. A rate increase of that magnitude would likely result people leaving the group for other carriers or, if healthy enough, choosing to forgo coverage altogether, leaving HIP with a smaller and sicker group. This is of utmost concern for the 2019 plan year due to the repeal of the individual mandate penalty and would inevitably subject HIP to a pricing death spiral. HIP would be better off with a smaller rate increase that would reduce the attrition of healthy members in its group.

B. HIP fails to provide any breakdown of its projected medical trend.

As discussed above, like many carriers, HIP does not offer adequate information about its medical trend assumptions. HIP's 5.5 percent medical trend may be below average, but HIP does not offer any explanation of how it arrived at this estimate. Greater transparency surrounding medical trend is not unreasonable—in fact, many carriers breakdown their trend in the same way the Milliman Medical Index does.[23] HIP should therefore be required to provide better information about its trend estimate.

[22] These are CDPHP, Empire Health Choice, Excellus, Healthfirst PHSP, HIP/Emblem Health, NYQHC/Fidelis, HealthNow, IHBC, MetroPlus, MVP Health Plan, Oscar, and Unitedhealthcare of New York. The applications cover both on- and off-exchange plans for all but MetroPlus and Oscar, which are only offering on-exchange plans. An additional four plans were offering plans off-exchange only, all with under 150 members. Those four plans were not included in the analysis for HCFANY's individual rate comments.

[23] Girod et al., "2018 Milliman Medical Index," Milliman Research Report, May 2018, http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf.

C. HIP's medical loss ratio goal is much lower than it has achieved in the last two plan years.

HIP appears to have had medical loss ratios of over 100 percent for two years: 103.8 percent for 2016 and 105.8 percent for 2017. For 2019, it projects a medical loss ratio of 84 percent. Putting aside whether such a dramatic reduction is realistic, the Department should simply require HIP to set a higher medical loss ratio goal. Even with a medical loss ratio of say, 93 percent (the 2017 marketwide average for plans with more than 200 members), it could retain a surplus and charge its members a more reasonable rate. Indeed, it has consistently retained 2 percent surplus since 2017—more than many other non-profit carriers—with a medical loss ratio of over 100 percent.

D. HIP does not adequately justify its high administrative costs.

For the 2019 plan year, HIP assumes a higher-than-average expense ratio of 14 percent. This high administrative cost is unsupported. HIP's nonprofit status means that HIP has an obligation to keep administrative costs low relative to other plans. However, HIP's 14 percent expense ratio is higher than nearly every other carrier on the market. For example, MetroPlus is only projecting administrative costs of 8.22 percent, and the much larger Fidelis estimates only 10 percent administrative costs.

Moreover, this high level of spending does not yield equally high member satisfaction. According to the 2017 New York Consumer Guide to Health Insurance Companies, the HIP HMO ranks near the bottom in the Overall Complaint ranking, coming in at number 40 out of 55 New York health insurance companies. The report further indicates that HIP members file grievances at a higher rate than all other New York insurance companies except Empire and United Healthcare.

The Department should devote extra scrutiny to HIP's above-average administrative costs and disallow increases to the extent that it exceeds the market average.

E. HIP says it is introducing cost-savings initiatives to Select Care plans, but it is unclear whether these savings are passed through to consumers.

HIP states in its Actuarial Memorandum that it is introducing "a number of cost savings initiatives" starting in 2018 and 2019 to the Select Care network. HIP acknowledges that the impact of these initiatives is to provide discounts to the Select Care network and reduce costs. Indeed, Row 5 of Appendix E shows a downward adjustment of 0.938 to reflect these savings.[24] However, this downward adjustment does not appear in Exhibit 18. If cost-savings initiatives—as their name would suggest—are implemented to save costs, then HIP should show some cost

[24] See, HIP 2019 Actuarial Memorandum, Appendix E, Row 5.

reduction resulting from these programs on Line 35 Exhibit 18 by using a factor of less than 1.00 on that line.

The Department should carefully review HIP's application to ensure that any cost-saving measures are passed on to its consumers in the form of lower rates.

F. HIP's projected impact of the individual mandate penalty repeal is unclear

In its Narrative Summary, HIP states that it must raise rates by over 30 percent due to the impact of adjusting the induvial mandate penalty to $0. However, the true impact of the penalty repeal on HIP's rates is not consistent throughout the Actuarial Memorandum. For example, Row 23 Exhibit 18 states that HIP estimates *no impact* of the removal of the penalty, but Line 7 Appendix E shows an upwards adjustment of 1.10 to account for the penalty repeal.[25] HCFANY asks the Department to require HIP to clarify the impact of repeal on its rates, submit accurate and consistent information across all sections of its Actuarial Memorandum, and to be transparent with its members and the Department about the reason it is raising rates.

Because of these inconsistencies, the Department should grant no adjustment to HIP for the impact of the individual mandate penalty repeal.

G. HIP does not adequately account for or explain provider network changes.

In 2018, HIP expanded its network for standard plans only. In 2016, HIP reduced its overall network by two percent, yet did not take a negative rate adjustment in its 2017 or 2018 rate application. In its 2019 rate application, HIP takes an 18.4 percent adjustment to account for the cost of moving Individual plans from the Select Care to Prime network. However, it does not explain why these costs were not fully accounted for in its 2018 rate increase. Therefore, it is unclear whether this upward adjustment is justified given the drastic cuts to its provider network two years ago.

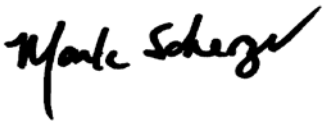
Additionally, HIP reiterates that it is keeping its narrow Select Care network. While HCFANY strongly believes in robust provider networks across all carriers, narrow networks mean fewer claims, and lower costs. These savings should be reflected in lower rates for members.

HCFANY urges the Department to review HIP's 2019 rate application with the highest level of scrutiny in light of the issues raised above.

[25] See, HIP 2019 Actuarial Memorandum, Exhibit 18, Row 23.

HCFANY urges DFS to carefully review the application submitted by HIP/Emblem. Thank you for your attention to these comments. Please contact us with any questions at adunker@cssny.org or 212-614-5312.

Sincerely,



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