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 – Healthfirst PHSP– Individual – 131487115

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 Healthfirst.

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.

Health Care For All New York
c/o Amanda Dunker, Community Service Society of New York
633 Third Ave., 10th Floor, New York, New York 10017
(212) 614-5312

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 health care and necessities like housing and food.[5] Those choices continue even after someone gains coverage as they make their monthly payments and 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

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[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 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 6 percent, which is the average across all carriers. Those carriers that filed adjustments below 6 percent should be granted the adjustments that they seek (e.g. 0 to 6 percent) and everything above would be reduced to 6 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

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[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 Healthfirst

With 29,055 members, Healthfirst is New York's third largest insurer. It operates in the New York City and Long Island regions. A notable feature is that Healthfirst has fairly low claims costs compared to other plans. Its average claims cost per-member per-month is only $335, much lower than the average (which was $511) and the third lowest in the market.[22]

Healthfirst is requesting an average increase of 15 percent for its 2019 rates. This is slightly below the average for New York's individual market (which was 17.8 percent) but is still high enough to cause hardship to its members. Healthfirst was one of only three carriers that lost individual market members between 2017 and 2018 (a 6 percent decrease). This is likely the result of last year's 17.7 percent increase in rates. Another large increase may drive even more customers away.

HCFANY has identified four issues to review for Healthfirst: its high expense ratio, its medical claims trend, its treatment of dental and vision coverage, and its redaction of information about its provider network.

A. Healthfirst's administrative costs are higher than average and increasing when they should be decreasing.

Across the individual market, carriers seek a 12.1 percent administrative cost request. Healthfirst requested 15 percent, one of the highest filed this year. Healthfirst is a nonprofit plan which should experience lower administrative costs. The only plans with higher administrative costs than Healthfirst are the for-profits Oscar and United.

In 2017, Healthfirst's administrative costs were only 12.8 percent. The company's administrative costs increased again last year to 14.6 percent. As discussed in the general comments, it is unclear why any carrier should experience increasing administrative costs after years of experience in this market.

There is no explanation in Healthfirst's Narrative Summary or Actuarial Memo for its increasing administrative costs. The Department should consider reducing this part of Healthfirst's request to its 2017 levels or below.

[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. 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.

B. **Healthfirst estimates a medical trend that is slightly lower than average, but as a provider-sponsored plan it might be expected to perform better than average.**

Healthfirst estimates a medical trend of 6.5 percent, which is less than the average requested trend for New York carriers (7.3 percent). However, in 2017, Healthfirst's trend was just 4.5 percent. Healthfirst's Actuarial Memo does not provide insight into why its trend is increasing when national experts suggest that trend is stabilizing or even decreasing over the same period of time.

As a provider-sponsored plan, Healthfirst is in an especially good position to negotiate contracts that should benefit its membership. Healthfirst was one of only four carriers to provide a full breakdown of its medical trend into inpatient facility services, outpatient facility services, professional services, and pharmacy. This is important information for the public for understanding insurance rates and for helping New York develop solutions for high premiums. Since there are only four full examples, comparisons may not be especially meaningful. However, it is interesting that Excellus reports lower trend rates than Healthfirst for inpatient services (2.9 percent versus Healthfirst's 3.6 percent) and professional services (1.4 percent versus Healthfirst's 3.6 percent). Healthfirst did perform the best of the four on outpatient facility services.

There is better information about how pharmacy trend compares across plans (eight of the twelve provided this information). Healthfirst's estimate for pharmacy trend was slightly above the average (11.5 percent versus 13.2 percent).

As noted above, HCFANY asks that the Department examine all the carriers' claim trends closely to look for areas in which the companies can better control costs. And while Healthfirst's trend is below the average sought by the other carriers, it should still be reduced given its own historical experience and that it is a provider-sponsored plan.

C. **Healthfirst appears to distribute the cost of dental and vision coverage to all plans, regardless of whether those services are covered.**

Healthfirst cites dental and vision costs as a 2.1 percent factor in its rate increase that would affect all Healthfirst plans, both standard and non-standard. However, standard plans do not offer dental and vision coverage and should therefore not be burdened with this portion of the rate increase. Additionally, non-standard plans that offer dental and vision coverage have higher monthly premiums, so the costs related to dental and vision coverage should already be accounted for in those higher premium rates.

The Department should require Healthfirst to justify why it seeks to assess a cost on these benefits that have already been factored into the premiums for non-standard plans and which should have no effect on the premiums for standard plans.

D. Healthfirst redacted information about provider rates.

Healthfirst redacted the amount of its provider reimbursement increases. Healthfirst's nonprofit status and its close relationship to the hospital industry should give it particularly strong bargaining power to keep rates low. Its status as a provider-sponsored plan also makes the rates it pays providers a matter of particular public interest. In any instance, redacting this pertinent information deprives consumers of their right to know what they are paying for when they choose a health insurance plan.

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

Sincerely,

Amanda Dunker, MPH
Health Policy Associate
Community Service Society of NY

Mark Scherzer, Esq
Legislative Counsel
New Yorkers for Accessible Health Coverage