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 – Oscar– Individual – 131494426

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 Oscar'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 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 income

[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/.

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

[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 Oscar

Oscar operates in New York City and Long Island and is the second largest carrier in New York's individual market. It currently has 50,816 members, about a 9 percent increase since 2017. As it does not offer Medicaid or Essential Plan products, Oscar members make up a large proportion of the people who purchase Qualified Health Plans on New York's exchange.

Oscar has the lowest average claims cost of the carriers participating in New York's individual market (only $313 per-member per-month, much lower than the average $510 per-member per-month).[22] Because of its healthy membership, Oscar is the biggest payer into the federal risk adjustment pool for New York. Its 2018 rates were below average (only $474 per-member per-month compared to $573 overall) and the second lowest available in the individual market.

Oscar's rate request for 2019 is an average weighted increase of 28.6 percent. This is the third highest request for 2019 and far above average (17.3 percent). Oscar does appear to be successfully controlling costs in some areas. For example, its medical trend request is 5.1 percent, the lowest in the state. Its pharmacy trend estimate is also the lowest (only 6.7 percent) and is below the 10.1 percent average reported overall.[23] However, given the size of its request, HCFANY asks that the Department scrutinize Oscar's application closely. Areas of concern include its high administrative costs, its treatment of the individual mandate adjustment, and its expected medical loss ratio.

A. Oscar has the highest administrative costs of any carrier in New York's individual market.

The average amount carriers requested for administrative costs for 2019 was only 12.1 percent. Oscar is requesting 17 percent. Oscar has historically asked for higher administrative costs than the other carriers: 25.1 percent in 2018 and 23.6 percent in 2017. While it is positive that Oscar's administrative cost request is lower than last year's request, it is still an outlier in the individual market.

In the past Oscar has used its status as a new plan to justify very high administrative costs. But 2019 will be Oscar's fifth year selling individual plans in New York, which should be

[22] The average includes 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] Actuarial Memo, page 8. Not all carriers provided information about pharmacy trend: 10.1 is the average of the pharmacy trends estimated by Excellus, Fidelis, Healthfirst PHSP, HealthNow, Independent Health, MetroPlus, MVP, and Oscar. CDPHP, Empire, HIP/Emblem, and United failed to provide enough detail to make comparisons with other plans.

adequate time to adjust to New York's market. As mentioned above, Oscar's growth rate was 9 percent last year in New York. It is, however, expanding rapidly in other insurance markets. HCFANY renews its concern, expressed in last year's comments, that New York's consumers are bearing the brunt of Oscar's expansion efforts through administrative cost increases.

HCFANY is also concerned that Oscar devotes more administrative costs to inappropriately denying claims than other plans. It is tied for the second highest rate of reversals for internal appeals in the state (55 percent reversed, compared to the average of 39 percent).[24] It ranked third from the bottom in the Department's overall complaint rankings, which are adjusted for size.[25] There have also been troubling reports that Oscar is using blanket exclusions to deny care to transgender people in violation of federal and state laws.[26] It is unclear if Oscar is complying with New York's anti-discrimination rules and it is concerning that Oscar has been documented violating these laws in other states. Those reports merit investigation by the Department and in any event, New Yorkers should not have to pay higher premiums to help Oscar manage legal issues arising out of its wrongdoing here or elsewhere.

The Department has reduced Oscar's administrative cost requests significantly in the past. For 2017 the Department reduced its request from 23.6 to 16 percent. For 2018 the request was reduced from 25.1 percent to 15 percent. The Department should consider reducing Oscar's administrative costs substantially again this year in light of its continually high requests, the possibility New York's rates are underwriting its expansion efforts, and its emphasis on denying claims.

B. Oscar is asking for a low adjustment to make up for losing the individual mandate, but it is unclear if it has accurately incorporated a corresponding downward adjustment in its expected risk adjustment payment.

Oscar asked for a 7 percent increase in premiums to make up for the loss of the individual mandate. This appears to be a reasonable request. It is slightly above the average (which was 5.8 percent), but it is sensible that Oscar expects a bigger impact than other carriers. Oscar's members use their health insurance relatively infrequently, reflecting their better than average health status. That makes them more likely than others to have been persuaded by the individual mandate and to opt against purchasing insurance without a penalty.

However, Oscar should also expect a reduction in its risk adjustment payment if it believes that its risk pool will deteriorate on losing the mandate penalty. That should mean Oscar will pay less into the risk adjustment pool because there will be a smaller gap between its risk profile and that of the other carriers. Last year Oscar adjusted its rate request up by 19 percent to account for its expected risk adjustment payment. This year, it is asking to increase its rates by 33 percent due to the risk adjustment program. That appears to indicate that it expects to make a

[24] New York State Department of Financial Services, "New York Consumer Guide to Health Insurance Companies," 2017," page 16, https://www.dfs.ny.gov/consumer/health/cg_health_2017.pdf.
[25] New York State Department of Financial Services, page 56.
[26] National Center for Transgender Equality and Out2Enroll, "An Open Letter to Oscar Health Insurance," June 20, 2018, https://medium.com/@TransEquality/an-open-letter-to-oscar-health-insurance-3fdf865d11.

higher payment into the risk adjustment pool this year rather than a lower payment, which contradicts its forecast of a larger than average impact from loss of the mandate.

The Department and the carriers have much more information about the effect of the individual mandate than the public can access or easily analyze. The information provided to the public does not provide an adequate explanation of the impact losing the mandate will have on Oscar's risk profile. It also does not provide adequate information to understand how those changes will affect its payment into the statewide risk adjustment pool. HCFANY asks that the Department examine this issue further.

C. Oscar's expected medical loss ratio is only 83 percent, a big change from its historical medical loss ratios without explanation.

Oscar's medical loss ratios over the past three years were 117.5 percent, 124.9 percent, and 98.1 percent. In its application for its 2019 rates, it expects a medical loss ratio of just 83 percent but fails to explain how it will achieve such a large reduction.[27] That goal is on the lower end of expected medical loss ratios for New York's individual market and just one point above the legally required minimum.

Further, it does not seem advisable for Oscar to attempt such a low medical loss ratio if doing so requires such a large rate increase. The Department should ask Oscar to justify its pursuit of such a low medical loss ratio so quickly, rather than pursuing a strategy of more gradual changes that might allow it to smooth out its rate increases over time. A 23.6 percent rate increase in one year risks driving customers away.

HCFANY urges DFS to carefully review the application submitted by Oscar. 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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[27] Actuarial Memo, page 8.