American Cancer Society ☙ Children's Defense Fund-New York ☙ Community Service Society of New York
Empire Justice Center ☙ Institute for Puerto Rican and Hispanic Elderly
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

August 1, 2014

Benjamin M. Lawsky
Superintendent of Financial Services
One State Street
New York, NY 10004

Mr. Charles Lovejoy
Health Bureau
New York State Insurance Department
25 Beaver Street
New York, NY 10004

Re: Requested Rate Changes – UnitedHealthcare of New York, Inc. – Individual On-Exchange

Dear Superintendent Lawsky and Mr. Lovejoy,

Health Care for All New York ("HCFANY") submits the following comments relating to the proposed average rate decrease of 5.8% for the individual market and a rate increase of 16% for its small group market plans, respectively, filed by UnitedHealthcare of New York, Inc. and United Healthcare Insurance Company of New York, (collectively "United") with the New York State Department of Financial Services (DFS) for the 2015 plan year.[1] HCFANY is a coalition of more than 160 consumer and small business health advocacy organizations dedicated to securing affordable, comprehensive, and high-quality health care for all New York residents. HCFANY believes that a robust prior approval process is a vital consumer

[1] These rate increase applications were submitted on or about July 2, 2014. Specific references refer to SERFF file number: UHLC-129581478 (hereafter "Rate Application").

protection. HCFANY urges DFS to review United's proposed decrease carefully to determine if it is appropriate. To this end, we submit the following comments.

I. The Affordable Care Act and New York's Insurance Marketplace

HCFANY urges DFS to consider the New York carriers' proposed rate adjustments in the context of the Affordable Care Act's (ACA) downward pressure on health care costs. Specifically, DFS should assess the impact of the following four factors on individual and small group prices in 2015.

1. Research indicates that the health cost curve is bending.

Lower overall healthcare costs should in turn drive lower premiums. The ACA includes several provisions designed to control spending, such as incentives for new healthcare payment and delivery methods (e.g. value-based payment vs. fee-for-service). For the past decade, data from across the payer spectrum indicates that the rate of health care costs increases is slowing down. This trajectory is likely to continue, as more ACA provisions are solidified.[2] For example, Medicare spending is about $1,000 lower per person than predicted in 2010.[3] PricewaterhouseCoopers projects a medical cost trend of 6.8% in 2015, a slight uptick from the 6.5% predicted in 2014 and down from the 7.5% cost trend predicted in 2013.[4] The 2014 Milliman Medical Index cites a 5.4% growth rate between 2014 and 2013, the lowest since the calculation began in 2012.[5] In short, as described in the table below, annual increases in national health care spending have been under 10% for the past 12 years, and have dropped significantly over time.

Average year-to-year percent increase in National Health Expenditures

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
6.6%	8.4%	9.7%	8.6%	7.2%	6.8%	6.5%	6.3%	4.7%	3.8%	3.8%	3.6%	3.7%

Source: National Health Expenditure Data[6]

[2] Blumenthal, D., Stremikis, K., & Cutler, D. (2013). Health care spending – a giant slain or sleeping? *New England Journal of Medicine, 369*(26), at 2551-2557.

[3] The mystery of the missing $1,000 per person: can Medicare's spending slowdown continue?. Kaiser Family Foundation, available at http://kff.org/health-costs/perspective/the-mystery-of-the-missing-1000-per-person-can-medicares-spending-slowdown-continue/.

[4] Medical Cost Trend: Behind the numbers 2015, PricewaterhouseCoopers, available at http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-medical-cost-trend-2015.pdf, at 6.

[5] 2014 Milliman Medical Index, Milliman, available at http://www.milliman.com/insight/Periodicals/mmi/2014-Milliman-Medical-Index/.

[6] Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf.

National research indicates that health insurance premium rates should be consistent with these lower health care costs. While pre-ACA rate increases averaged 10%,[7] the Congressional Budget Office predicts only a 3% rise in Marketplace premiums for 2015.[8] And just last week, California announced an average increase in its Marketplace plans of just 4.2% for 2015.[9] Additionally, the 2014 Trustee Annual Medicare Report predicts that Medicare premiums will hold steady in 2015.[10]

In New York, according to a newly released DFS survey of carriers, New York's insurance plans have been early adopters of many of the ACA-related and other state health care cost reforms initiatives, such as value-based purchasing and patient-centered medical homes.[11] Other reports provide evidence that ACA and New York State delivery system reforms are indeed resulting in cost reductions amongst all payers.[12]

The carriers' rate filings should include adjustments in 2015 which reflect the bending of the health care cost curve and the cumulative efforts of New York's payment reforms. For example, New York's Medicaid Redesign Team initiatives, the State's new Delivery System Reform Incentive Payment Program (DSRIP) and State Health Innovation Plan (SHIP) all employ delivery and payment system reforms that further reduce health care costs for the entire delivery system. Despite likely savings that will be generated from these reforms, only one carrier (Excellus) took a downward adjustment to account for quality improvement and cost containment strategies.[13] We urge the DFS to consider New York carriers' rate proposals in light of the impact of the ACA.

[7] Gruber, J. (June 2014). Growth and variability in health plan premiums in the individual insurance market before the Affordable Care Act. *The Commonwealth Fund, 1750*(7), at 2.
[8] Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014. Congressional Budget Office, at 6.
[9] Covered California Press Release, July 31, 2014. Available at http://news.coveredca.com/2014/07/covered-california-announces-rates-for.html.
[10] 2014 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. (July 28, 2014). Available at http://apps.washingtonpost.com/g/page/national/2014-medicare-report/1220/#text/p93, at 87.
[11] A number of plans have accrued health reform savings. New York State Department of Financial Services. (July 2014). New York health care cost and quality initiatives. Available at: http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf. For example, United Healthcare's "Accountable Care Shared Savings" program saved over $200,000 due to decreased inpatient and emergency room utilization; HealthNow's "Facility Quality Incentive Program" saved over $3 million; and Excellus' "Rochester Medical Home Initiative" reported a 1.2:1 return on investment).
[12] *See, e.g.* Silow-Carroll, S & Edwards, J.N. (2013). Early adopters of the Accountable Care Model. Commonwealth Fund, pp. 19-20; U.S. Dept. of Health and Human Services., Press Release: Medicare's delivery system reform initiatives achieve significant savings and quality improvements– off to a strong start, (Jan. 30, 2014). Available at http://www.hhs.gov/news/press/2014pres/01/20140130a.html.
[13] Excellus Health Plan, Inc., Exhibit 18, Line 17.

2. The 2015 risk pool is likely to be lower-cost than in 2014, according to the Congressional Budget Office (CBO) and American Academy of Actuaries.[14]

In general, the CBO predicts that the healthier risk pool in 2015 will lower premiums relative to 2014.[15] There are three reasons why New York is particularly likely to experience this downward trend: (1) higher than expected enrollments should result in increased carrier bargaining power; (2) the sickest consumers were more likely to have enrolled in year one; and (3) pent-up demand is likely to be concentrated in year one when more uninsured enrolled.

The first of the three reasons supporting this prediction is that New York carriers have experienced higher than expected enrollments, due to the remarkably successful launch of the NY State of Health Marketplace. In just the first nine months, over 1.2 million New Yorkers have enrolled in Qualified Health Plans and Medicaid Managed Care plans, 84% of whom were previously uninsured.[16] This exceeds the State's *three-year* enrollment goal of 1.1 million enrolled by the end of 2016. Carriers can, and should, leverage this increased customer base to reduce provider and other costs, due to economies of scale and the related increase in bargaining power with health care providers.

The second reason for a lower-cost risk pool in 2015 than in 2014 is that individuals with higher health care needs are more likely to have signed up during the first 2013-2014 open enrollment period.[17] In 2015 and beyond, healthier individuals are more likely to enroll as the individual mandate penalty increases. Therefore, the 2015 risk pool is likely to be healthier than in 2014.

The third reason is that pent-up demand for services from previously uninsured should be concentrated in 2014. In building their 2014 rates, carriers already captured generous pent-up demand adjustments. Indeed, the vast majority (84%) of the over 1.1 million NY State of Health enrollees were uninsured. Moving forward, there is no evidence that the 2015 enrollees are likely to have the same rates of uninsurance. Moreover, the 2015 new entrants likely postponed enrolling in coverage because they are healthier and are less likely to have significant pent-up demand. In short, there is no need for a second year of pent-up demand adjustments and in fact, DFS should secure a

[14] *See,* Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014. Congressional Budget Office. p. 7; Drivers of 2015 Health Insurance Premium Changes. (2014). American Academy of Actuaries, at 2.
[15] Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014. Congressional Budget Office, at 7.
[16] NY State of Health Public Marketplace Data Report as of June 30, 2014.
[17] *See,* Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act, April 2014. Congressional Budget Office. p. 7; Drivers of 2015 Health Insurance Premium Changes. (2014). American Academy of Actuaries, at 2.

downward adjustment from the carriers for the likely reduction of pent-up demand in 2015 versus 2014.

As noted above, California's regulators leveraged their bargaining power to secure only an average 4.3% rate increase for its Marketplace products, with many consumers seeing price decreases.[18] Accordingly, DFS should review the carriers' rate proposals with the assumption that the 2015 pool should present overall *lower* health risk to insurers than the 2014 pool and a commensurate downward adjustment for lower risk and small pent-up demand should be ascribed to all carriers.

3. New federal risk adjustment, reinsurance and risk corridor programs are designed to defray carrier rate increases related to increased risk and market uncertainty.

The ACA provides new risk adjustment and reinsurance programs to address increased risk by insurers and to assure stable prices for consumers and small employers. The ACA's reinsurance payments, designed to reduce rate increases based on less healthy risk pools, are expected to result in premium decreases between 10 and 15%.[19] Historically, New York's now expired risk adjustment program reduced prices by up to 30%.[20] New York carriers are proposing reinsurance adjustments between 5.75% and 6.10 % on average for on- and off-Marketplace plans, which are inconsistent with these projections and the State's historical experience. Moreover, a review of the New York carrier filings indicates that the majority of carriers in the individual markets proposed no adjustments for the federal risk adjustment program. Finally, none of the carriers have adopted adjustments for the federal risk corridor program, which protects the carriers from unanticipated risk selection. On behalf of New York's consumers and small employers, DFS should ensure that fair adjustments attributable to the impact of the federal risk adjustment, reinsurance, and corridor mechanisms are applied to the carriers in its review.

4. The New York State carriers' rates should reflect a downward adjustment for a decrease in administrative costs.

The NY State of Health Marketplace reduces administrative costs for carriers related to compensation of agents/brokers, enrollment and marketing costs. Only 6% of NY State of Health enrollees sought help from a broker/agent during the first open enrollment period, while 43% got

[18] *Id.* n. 9.

[19] Establishment of Exchanges and Qualified Health Plans, Exchange standards for employers (CMS-9989-FWP) and standards related to reinsurance, risk corridors, and risk regulatory impact analysis, Center for Consumer Information & Insurance Oversight, Adjustment (CMS-9975-F). (March, 2012). Center for Consumer Information & Insurance Oversight, U.S. Dept. of Health & Human Services, at 42.

[20] *Id.* at 43.

help from other in-person assistors, and the remainder enrolled via the helpline and the website.[21] Additionally, the individual mandate as well as marketing and outreach efforts by NY State of Health should reduce marketing expenses for carriers.

Each carrier filing must be considered in the context of the above mentioned environmental factors. Our specific concerns about the United's rate application are described below.

II. Specific Issues in United's Rate Application

HCFANY urges the DFS to consider all of the above factors when reviewing United's rates. Further, the DFS should be mindful that United's 2014 rates are substantially higher than all others in the individual markets, as it reviews this rate adjustment application. The United 2014 New York City platinum-level plan prices are already between 144% and 204% more expensive than the next most expensive and lowest cost plans, respectively.[22] DFS should consider whether United's proposed decrease of 5.8% is sufficient. Moreover, United does not provide a clear justification for the significant discrepancy of its proposed rate decrease in its individual and the rate increase in its small group products (-5.8% vs. 16%). Additionally, United's actuarial memo and Exhibit 18 (the Index Rate and Plan Level Adjustment Worksheet) raise the following specific concerns.

A. The Initial Index Rate Factor

United's initial index rate factor of $416.63 is significantly higher than nearly all of the individual market applications filed with DFS to sell Individual On-Marketplace products in 2015.[23] This rate is nearly 1.5 times the average base rate ($324) of all the other on-Marketplace carriers. Because United's base rate is so high, DFS should be mindful that even with United's proposed decrease, its rates may remain disproportionately high as compared with other plans, as described above. DFS should consider closely the justification for using this relatively high initial index rate as it reviews the United application.

B. The Annual Medical Trend

In addition to a high initial index rate, United cites a trend increase of 10.9% for its individual and small group plans, which is among the highest of any carrier in either market.

[21] 2014 Open Enrollment Report. (June 2014). NY State of Health: The Official Health Plan Marketplace, at 16.
[22] United's New York City platinum-level plan is $896.39. The next most expensive platinum-level plan is Empire Blue Cross at $620.69. The lowest cost New York City platinum-level plan is Metro Plus' PlatinumPlus-P1 plan, which is $443.24.
[23] United's proposed Initial Index Rate Factor of $416.63 is lower only than Empire's Initial Index Rate Factor of $437.53. *See* Exhibit 18, line 10.

This rate is nearly double the PricewaterhouseCoopers national estimate of 6.8%.[24] As described above, several factors will likely contribute to lower costs in 2015, including a healthier risk pool, delivery system reforms, and federal risk adjustment and reinsurance programs.

United explains that its trend factor breaks down into 4.1% unit cost, 5.5% utilization, and 1.0% trend leveraging.[25] This 5.5% utilization increase appears to be inconsistent with a 15.6% decrease in induced demand cited in the preceding paragraph of United's actuarial memorandum. The DFS should closely review intra-application discrepancies such as this. Further, United does not explain how each of the components in its trend factor is derived. The DFS should require that all carriers, including United, provide supporting exhibits to justify any such figures in their memos, so that the Department and consumers can verify their validity.

C. Increased Morbidity and Population Changes

United cites a 21.4% upward adjustment for increased risk in the individual market as compared with the small group market. This breaks down into a 15.6% adjustment for age/sex of the individual market and a 5% adjustment for increased morbidity. DFS should closely scrutinize this adjustment for three reasons.

First, United indicates that it used NY OHI Large Group filed age/sex factors to calculate the 15.6% adjustment, though it does not state how or why.[26] This could lead to an inflated age/sex factor if United is using large group data as a proxy for its small group data, as large group age/sex factors are likely to be lower than small group factors. Second, while United cites a 5% increase in morbidity, as described in detail above, experts have noted that the 2015 risk pool is likely to have *lower* morbidity than the 2014 pool, resulting in a lower-risk pool overall. Third, an age factor can be used to approximate increased morbidity for a population, as older populations tend to have higher morbidity than younger populations. Thus, use of both age/sex and morbidity factors may constitute double counting.

DFS should therefore review this calculation carefully to assess whether or not United is double-counting in applying upward adjustments both for age/sex and for morbidity. It should also be mindful of the fact that the initial pricing of the individual product for 2014 was already built upon many of these same distinctions between individual and small group rates. To apply

[24] Medical Cost Trend: Behind the Numbers 2015, PricewaterhouseCoopers, available at http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-medical-cost-trend-2015.pdf, at 6.
[25] Actuarial Memorandum, at 7.
[26] Actuarial Memo, at 4.

these adjustments again in 2015 potentially exaggerates the pricing differences between the two markets over time.

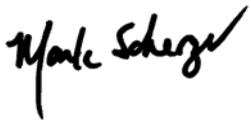
D. Provider Network Resizing

HCFANY urges DFS to carefully scrutinize United's rate application to determine if an adjustment was made to reflect its "resized" network. United is requesting approval of a decreased provider network of 15.7% over its Freedom Network.[27] Many carriers are using narrow networks for their Marketplace plans in order to control costs and offer lower premiums to members. A recent Milliman report indicates narrow networks can result in premium reductions of 5% to 20% when compared with broad network plans.[28] However, United's rate filings do not appear to accompany its reduction of network size with concurrent savings to its customers: notably, United makes no adjustment for network size on Line 14 of its Exhibit 18. The DFS should carefully review United's application to ensure that cost savings related to its network adjustment are distributed to its customers.

III. Conclusion

HCFANY urges the Department to closely review United's application in light of the issues described above. Thank you for your kind attention to our concerns. If you have any questions, please contact Mark Scherzer at mark.scherzer@verizon.net or at (212) 406-9606 or Amanda Peden at apeden@cssny.org or at (212) 614-5541.

Very truly yours,



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[27] Actuarial Memo, at 5.
[28] High-value Health Care Provider Networks. (July 1, 2014). Milliman, available at http://www.ahip.org/MillimanReportHPN2014/, at 1.