American Cancer Society ღ Children's Defense Fund-New York ღ Coalition for Asian American Children and Families ღ Community Service Society of New York ღ Empire Justice Center ღ Make the Road New York Medicare Rights Center ღ Metro New York Health Care for All Campaign ღ New Yorkers for Accessible Health Coverage ღ New York Immigration Coalition ღ Public Policy and Education Fund of New York/Citizen Action of New York ღ Raising Women's Voices-New York ღ Schuyler Center for Analysis and Advocacy ღ Small Business Majority

June 24, 2016

Maria T. Vullo, Acting 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 – Empire – INDIVIDUAL – AWLP 130548296

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

Health Care for All New York (HCFANY) submits the following comments relating to Empire's proposed 25 percent increase for their 2017 individual rates. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected in policy decisions.

HCFANY believes that a robust and public prior approval process is a vital consumer protection, and thanks you for the opportunity to submit comments. The first section below describes our market-wide concerns. The second section describes our specific concerns around Empire's rate application.

I. Market-Wide Issues

A. Carriers are not providing sufficient information to justify their proposed rate increases

HCFANY believes strongly in the public rate review process. Health insurance and health care are a major part of most New Yorker's budgets, and something over which consumers have poor information and limited freedom of choice. Public rate review provides some balance of power between consumers and carriers, and carriers must be expected to follow both the letter and the spirit of the law. That means providing transparent, reasonable justifications supported by evidence in order to receive rate increases.

Many of the 2017 applications are opaque and rely on hidden assumptions. As described in our May 25, 2016 letter, some carriers inappropriately redacted important information, most notably Affinity, Oscar, Excellus, Fidelis, and Crystal Run. However, other carriers provided a good amount of information—for example, Independent Health's Actuarial Memo was clearly written and explained their assumptions with a reasonable amount of detail. However, almost all of the other applications in both the individual and small group market failed to provide cogent and clear justifications for their rate applications.

The increases requested this year represent millions of dollars for New York's consumers. HCFANY recognizes the need for carriers to make adjustments for legitimate administrative expenses and reasonable medical trend increases. However, most of New York's carriers have failed to provide adequate explanations for their requests. HCFANY urges the Department to scrutinize the carriers' respective actuarial memos closely and provide feedback about the transparency of their assumptions. In particular, the Department should provide clear and uniform guidance to the carriers and the general public about what information should be included in the carriers' actuarial memorandums. Future rate increases should be rejected whenever inadequate information is provided in the carriers' actuarial memorandums.

B. <u>The 2017 risk pool will likely be the healthiest yet</u>

The 2017 risk pool is likely to be healthier than prior years for two reasons: (1) younger and healthier people will be enrolling in plans because of the increased individual mandate penalty; and (2) the impact of the Basic Health Plan has essentially already been incurred.

First, the marketplace can expect an infusion this year of healthier and younger enrollees, including so-called "young invincibles," who may have been willing to bear the modest tax penalties through 2015 but, when faced with a more than doubling of the maximum penalty (to $695 per adult individual, $2085 per family) for 2016. Those who paid the penalty for 2015 and thus became aware of the increased penalties for 2016 and beyond are likely to migrate into the marketplace during the next open enrollment period, improving the risk balance in the market. This was the effect of the increased tax penalties in Massachusetts in 2007.[1] We should expect a similar effect in New York.

Second, the Department should not allow three carriers to take their requested marketplace-wide adjustments for the impact of migration of many New Yorkers from the individual market to the Basic Health Plan (Essential Plan) program.[2] We understand that the Department directed plans to address the impact of Basic Health Plan by removing the claims of these members as they build their initial index rates. This process should have occurred in

[1] The Importance of the Individual Mandate – Evidence from Massachusetts, http://www.nejm.org/doi/pdf/10.1056/NEJMp1013067, at 295.
[2] *See, e.g.,* Empire, Excellus, HealthFirst, HIP, Actuarial Memoranda citing a non-public New York State Market Wide Risk Adjustment Simulation prepared by Wakely Actuarial for the New York State Department of Financial Services. *See, also,* Oscar and United Health's Exhibit 18 seeking second year adjustments for the Basic Health Program.

advance of the Marketplace adjustments, consistent with the directions provided to the carriers in advance of this year's prior approval process. Several carriers appear to have ignored those directions. It should be noted that several plans did not seek another morbidity adjustment for the Basic Health Plan in their 2017 requests (*see, e.g.* MetroPlus).

HCFANY urges the Department to consider that these market-wide factors mean that the New York individual market risk pool will likely be its healthiest and ensure that the 2016 premiums are set accordingly, with reductions, rather than increases, based on projected morbidity.

C. Medical trend is increasing slowly and should be more standardized.

Medical costs are increasing at a slower rate than before the enactment of the Affordable Care Act. For 2017, the Milliman Medical Index projects an increase in medical costs of only 4.7 percent overall.[3] This is the lowest annual increase since the index was first calculated in 2001. PriceWaterhouse Cooper's Health Research Institute projects an increase in medical costs of 6.5 percent for 2016.[4] Accordingly, an appropriate medical trend adjustment for 2017 should be somewhere between 4.7 and 6.5 percent.

For the most part, however, the New York 2017 rate filings include estimates that are much higher than these national expert estimates. (*See, e.g.,* Empire 12.5 percent, Affinity 9.1 percent, United 9 percent and Care Connect 8 percent). In addition, carriers filed medical trends that vary widely, meaning that some plans are asking for much larger increases than other plans in New York: the individual market applications' trend range from 3.5 percent (MetroPlus) to 12.5 percent (Empire) and the small group market applications' trend range from 4.3 percent (MetroPlus) to 12 percent (Aetna).

New York State should require greater standardization amongst the plans being sold on the New York State of Health (NYSOH) Marketplace. Carriers have some control over the two primary components of medical trend, which are prices and utilization. While there are differences in the circumstances carriers face within New York State and within a standard structure like the NYSOH, the large variation in medical trend projections indicates either that some of the plans are not managing medical trend as well as others, or that plans are not basing projections on appropriate data. On prices, for example, carriers can negotiate favorable contracts. However, the largest plans which are presumably in the best position to negotiate for lower prices, are projecting some of the biggest increases in medical trend (for example, Aetna in the small group market and Empire in the individual market).

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[3] Chris Girod et al., "2016 Milliman Medical Index," at 15. May 25, 2016, http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2016-milliman-medical-index.pdf. Their estimates by type of service are: 4.2 percent for inpatient, 5.5 percent for outpatient, 2.5 percent for professional services, and 9.1 percent for pharmacy.

[4] Health Research Institute, "Medical Cost Trend: Behind the Numbers 2016," June 2015, http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-medical-cost-trend-2016.pdf.

Assertions about increases in utilization should be scrutinized carefully. There is no convincing reason that the 2017 individual or small group pool will be less healthy than the 2016 pool or need more health services. In fact, as described earlier, the pool is likely to be healthier than ever. There was no large change in the insured rate compared to the first years of ACA implementation. Inpatient hospital utilization, the biggest component of medical claims, has been decreasing for years and experts at Milliman suggest that there is unlikely to be any increase in 2017.[5] Additionally, some of the state's payment and delivery system reform efforts should start to pay off in 2017 through deceases in utilization. Many of the quality improvement efforts underway through the State's DSRIP and SHIP programs, for example, will benefit everyone who uses the associated hospitals without requiring an investment from carriers.

Projected increases in pharmacy utilization and prices are of special concern. Several carriers suggest that new expensive drugs will drive up both costs and utilization. Many of those same carriers requested (and received) rate increases last year in response to the new Hepatitis C drugs, yet offered no evidence that these drugs were actually approved for use by their members. Indeed, independent evidence is to the contrary. New York's Attorney General recently investigated and reached a special agreement with seven of the plans requesting increases this year over their failure to fairly cover Hepatitis C treatment, and is suing an eighth, Capital District Physicians' Health Plan.[6] Moreover, those carriers who received increases because of the Hepatitis C drugs last year should not receive an increase for a second year, absent specific evidence of increased utilization by their membership. Finally, any costs for the new drugs for Hepatitis C treatment, which is essentially curative, should be offset by the savings from not having to offer chronic treatment for the condition after the one-time cost for this drug is incurred.

We urge the Department to carefully scrutinize the filings of plans with outsized medical cost trend projections in light of their filings in prior years as well. It seems clear that some have over-estimated anticipated costs in the past, leading to their failure to meet either projected or statutory minimum medical loss ratios, and an obligation to refund premium overpayments to their enrollees. The methodology of those plans should be treated with particular skepticism. They should be requested to explain to the Department both how their past projections have proved so unreliable and how their methodology has changed.

D. Administrative costs should be decreasing and should be more standardized

Administrative costs range widely from 8.4 percent (MetroPlus) to 28.7 percent (Oscar) in the individual market and 9.6 percent (MetroPlus) to 27.5 percent (Crystal Run) in the small group market. Generally, administrative costs should be decreasing. As HCFANY argued last year, the New York State of Health site greatly eases the administrative burden on plans because

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[5] Chris Girod, at 14.

[6] Press Release: A.G. Schneiderman Announces Major Agreement With Seven Insurers to Expand Coverage of Chronic Hepatitis C Treatment for Nearly All Commercial Health Insurance Plans Across New York State, April 26, 2016, http://www.ag.ny.gov/press-release/ag-schneiderman-announces-major-agreement-seven-insurers-expand-coverage-chronic and Ed Silverman, "New York attorney general sues insurer for restricting hepatitis C drugs," April 18, 2016, *Stat*, https://www.statnews.com/pharmalot/2016/04/18/hepatitis-drug-prices-gilead-merck/.

New York State conducts marketing, outreach, and enrollment for all of the plans that sell there. Carriers have had several years of experience with the changes required by the ACA and should by now have fully developed systems for managing those plans.

A few carriers mention decreasing administrative costs in their applications as part of discussions on their strategies for keeping rates low. HCFANY believes that there should be much more emphasis on this strategy by all plans, and that plans requesting rate increases (especially large, double-digit increases) should provide a detailed discussion of their efforts to keep administrative costs down.

Additionally, carriers should provide more information about the components of their administrative spending. Analyzing the variances between spending on things like executive salaries, commissions, advertising, government relations, processing appeals, and utilization management would allow for more meaningful comments. A related consideration ought to be whether plans are accumulating excess reserves which might more appropriately be applied to premium reductions.

E. The Medical Loss Ratio requirement should be a floor, not a goal, and plans should honor the requirement before requesting increases.

HCFANY believes that the 82 percent minimum medical loss ratio (MLR) required by New York State should be a floor, not a goal. A number of plans in both the individual and the small group market did set goals above 82 percent this year, but HCFANY urges the Department to closely review the submissions of those carriers that project MLRs of only 82 percent or slightly above, and especially those carriers that failed to provide an estimate in their public applications (which includes Excellus, HIP, MVP, and Fidelis).

Carriers who have failed to meet medical loss ratios over the years should not be eligible for increases this year. The Department should carefully review their applications for an assessment of whether their premiums are either too high or they are paying too little on medical claims, or both. For example, in the individual market, Affinity and Empire failed to meet the 82 percent minimum in both 2014 and 2015. (Affinity's MLR in 2014 and 2015 was 58 percent and 77 percent, respectively; Empire's MLR, according to Exhibit 13A of its application, was less than 70 percent in 2014 and 79 percent in 2015). In the small group market, Capital District Physicians Health Plan, Empire, Healthfirst, and Oxford failed to meet the statutory MLR in both years. Other plans have failed to meet the MLR in one year or the other. None of the plans offer any discussion about why that failure occurred or how they will improve in their rate filings. This failure demonstrates either poor stewardship of consumers' premium dollars or previous rate increases granted upon inappropriate data and assumptions. Therefore, these plans should not be eligible for rate increases in 2017.

F. Carriers with small provider networks should do more to decrease rates.

Although HCFANY does not endorse narrow networks and has serious concerns about consumers' inability to find appropriate care within the networks in which they are enrolling, it is

clear that insurers have been engaged in concerted efforts to create narrow networks, particularly for marketplace products. The overall size of networks in New York State is small: 39 percent were classified as small in a 2015 study that looked at silver-level plans, meaning that the network included only 10 to 25 percent of area physicians.[7] Very few plans made any adjustment for the size of their provider networks, but it is likely that overall network size has been decreasing in New York's market as it has nationally.

Carriers which have reduced their networks should likewise be reducing their premiums charged to consumers consistent with their network reductions. For example, the Kaiser Family Foundation estimates that the smallest networks can save carriers 20 percent.[8]

Overall, the Department should require carriers to provide much more information about their changes in network size from year to year. Carriers should also be required to identify those products that use narrow networks when requesting increases. Consumers are unable to judge the size of networks before purchasing plans and therefore cannot make meaningful decisions about the tradeoffs between network size and premium expense. This means that the Department has to be especially vigilant about this aspect of rate setting.

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

II. Empire's Rate Application

Empire's request for an overall 25 percent (range 20 to 27 percent) increase is the second highest in the individual market and should be closely reviewed. HCFANY's biggest concerns are Empire's high annual claims trend projections, their track record of inaccurate MLR projections, and their unsupported requested adjustments for the special enrollment period for pregnancy, provider network, quality improvement, and the Essential Plan.

A. Empire's annual claims trend projection is the highest in the individual market and is not supported.

Empire's 25 percent rate increase request is premised in part on a projected 12.5 percent trend factor. Empire estimates this 12.5 percent increase even though the only two independent authorities it cites contradict the amount of its request: a Deloitte study showing overall medical costs increasing at a 6 percent rate and a PWC study estimating physician cost increasing at 5 percent. Empire's actuarial memorandum states that its trend estimates are based on internal claims experience, but as described below, its claimed 12.5 percent trend is unconvincing.

[7] Leonard Davis Institute of Health Economics, "State Variation in Narrow Networks on the ACA Marketplaces," August 2015, http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf.
[8] Gary Claxton and Larry Levitt, "What to Look for in 2017 ACA Marketplace Premium Changes," Kaiser Family Foundation, May 5, 2017, http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/.

Empire's actuarial memorandum points to a significant increase in claims experience from 2014 to 2015. And indeed in 2014 it is clear that Empire enjoyed a dramatic respite from paying claims, achieving just a 69 percent MLR. Empire acknowledges that what it calls "artificial suppression in claims" may have resulted from enrollment and network problems which prevented enrollees from using their benefits in 2014. As a result, it claims that its proposed trend rate of 12.5 percent is discounted. However, this trend adjustment appears entirely arbitrary given the suppression of claims payment in 2014. Empire justifies its calculation by pointing to a similarly large year to year jump in claims payment from early 2015 to 2016, suggesting that there is indeed a trend of increased utilization, but that suggestion relied on the assumption that its artificial claim suppression was confined to 2014 and did not carry over into 2015. Empire's failure to meet MLR targets for 2015, spending only 79 percent of premium dollars on medical claims, suggests that the artificial claim suppression continued into that year. Alternatively, Empire's actuarial methodology is severely flawed and should not be credited.

The Department should press Empire to describe how its methodology in estimated claims cost has changed from the prior two years, and how it explains the differences in its claim cost projections in light of the national predictions of Milliman and PWC cited above. It is not sufficient for Empire to say, as it does in its narrative summary, that the population is becoming "less healthy," particularly in consideration of the likelihood, explained above, that the increase in tax penalties for failing to buy coverage will result in the exchange this year having the healthiest risk pool yet. Alternatively, the Department should simply approve a modest increase in claims costs of 5.6 percent, the average of Milliman and PWC.

The prescription drug component of Empire's claims trend projections also deserves scrutiny. Empire attributes high additional costs from the availability of new drugs for Hepatitis C and other drugs for other conditions in the "drug pipeline." While consumers are happy that Empire is now covering the new drugs, its projection seems to weigh only the cost of the treatment and not the savings in overall medical expense achieved from what is essentially cure of a chronic disease that demanded ongoing high cost treatments. The Hepatitis C treatment, in particular, is a one-time expense which should not be built into the premium base for the long term.

Finally, Empire attributes a nearly 1 percent adjustment in experience to the special enrollment period for pregnancy adopted by the New York Legislature. This adjustment is entirely unwarranted. The facts the Legislature took into account in passing the law included that the need for this benefit would be relatively rare, and that there would be an overall reduction in medical expenditures for both the women and their children if we ensure that pregnant women receive adequate pre-natal care.

B. <u>Empire has a track record of inaccurate MLR projections and of not meeting New York's legally required minimum MLR.</u>

Empire's MLR projections should be treated skeptically, given its track record of inaccurate actuarial projections. In each year since the ACA has been in effect, Empire has

projected that its claims costs would be at least 82 percent of its premiums received, to meet New York's mandatory medical loss ratio requirements. But it has yet to actually spend enough on claims to meet its MLR requirement. In 2015, claims costs were just 79 percent of premiums received, and in 2014 they were, according to Empire's Exhibit 13A, under 70 percent. And the 2015 shortfall was after the Department cut Empire's requested 18.4 percent increase to just 7.4 percent. Had the actual rates requested been granted, Empire's claims expenditures would have been even further from the projected levels.

Further, the Department should question whether Empire is using the individual market as a profit center to subsidize its competitive efforts in the large group market. Empire's annual report for 2015 shows that for its entire business, the proportion of claim costs to premium received was over 83 percent. The fact that it spends less on claims in the individual market, where consumers have less bargaining power, suggests a persistent pattern of using high profits in the individual market to offset more aggressively bargained prices in the group market.

C. Empire is the only plan that took an upward adjustment for provider network size.

For the second year in a row, Empire is requesting an upward adjustment for network size (4 percent this year, and 4.7 percent last year). HCFANY believes that this claim should be closely investigated by the Department given consumer complaints that Empire's networks are actually downsizing.

Empire claims that hospital consolidations are reducing its bargaining power and leading to higher costs for hospital services, attributing this adjustment to "erosion in provider discounts." However, this is a national trend and should be affecting medical cost inflation everywhere. The credible estimate of medical inflation from Milliman undoubtedly accounts for a similar contracting dynamic nationwide, and yet it only projects trend at half that of Empire. Further, Empire in particular has been creating narrower networks of hospitals and other medical providers, which should be providing it with a counterbalance to any increased bargaining power in the hospitals. Nor should the similar bargaining power effects of the proposed Anthem merger with Cigna be ignored.

D. Empire only counts the cost of quality improvement efforts and not the benefits.

Empire attributes over $6 per member per month in additional costs from quality improvement measures such as wellness programs and programs to reduce hospital readmissions. The fundamental thrust of these programs is to produce overall improvements in health and well-being, which in turn reduces medical costs. As described above, Empire made a similar inappropriate assumption in counting only the costs of new drugs and the special enrollment period for pregnancy. To again weigh only the costs of the programs without the reductions in costs which should be their benefit is unreasonable. If the programs are not improving health and reducing costs, they should not be pursued.

E. Empire is one of the plans that may be miscounting morbidity changes caused by the Essential Plan.

Empire's application also requests a 3.2 percent adjustment for morbidity because of the creation of the Essential Plan, contrary to the filing instructions provided by the New York State Department of Financial Services. Empire simply should have removed these members from its base rate calculation, in accordance with the Department's filing instructions. As described above, this year's marketplace plans are likely to have the healthiest risk pool yet.

III. Conclusion

Overall, Empire's actuarial projections should be viewed with considerable skepticism, given the issues described above and the harm it would do to consumers. Even with the dramatic and apparently unanticipated increase in claims costs from 2014 to 2015, which Empire attributes to artificial claim suppression in 2014, and even with Empire not having been granted the full increase in premium it requested for that year, Empire still failed to meet its MLR projection for 2015 (achieving just a 79 percent MLR) and will be required, by its calculations, to rebate over $3 million to consumers. The article in the New York Times this week suggesting that companies like Empire are using their large group plans to subsidize the individual indeed seems to have missed that Empire is consistently taking in too much money in premiums in its individual plans and achieving a lower MLR there than in its business overall.[9] If anything, the subsidy may be going in the other direction.

In judging Empire's rate request, the Department should look at the benefits as well as the costs of the medical expenditures Empire points to in its rate request. Where the expenditures are intended to and are reasonably anticipated to produce overall reductions in claim costs, they should be reflected as downward, rather than upward adjustments to premium rates. In assessing medical trend, the Department should rely on credible outside sources (we suggest averaging Milliman and PWC to arrive at a 5.6 percent rate) rather than on Empire's entirely unconvincing numbers.

Thank you for your attention to these comments. Please contact us with any questions at adunker@cssny.org or 212-614-5312.

Sincerely,

[9] Reed Abelson, "Health Insurer Hoped to Disrupt the Industry, but Struggles in State Marketplaces," *New York Times*, June 19, 2016, http://www.nytimes.com/2016/06/20/business/struggling-for-profit-selling-health-insurance-in-state-marketplaces.html?_r=0.

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