American Cancer Society ☙ Children's Defense Fund-New York ☙ Coalition for Asian American Children and Families ☙ Community Service Society of New York ☙ 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 ☙ 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

June 16, 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 – NorthShore LIJ CareConnect – INDIVIDUAL– NSCC-130554999

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

Health Care for All New York (HCFANY) submits the following comments relating to NorthShore LIJ CareConnect's proposed 29.2 percent increase for their 2017 Indivdual 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 NorthShore LIJ CareConnect's rate application.

I. Market-Wide Issues

A. <u>Carriers are not providing sufficient information to justify their proposed rate increases.</u>

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 a 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] In some cases, these

[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.

adjustments amounted to as much as a 3.6 percent increase in morbidity. Most plans already made an even higher adjustment of 4.3 percent (based on an earlier Deloitte Report commissioned by the Department) when they filed their 2016 rate applications. Accordingly, nearly all plans should have an adjustment for the roll out of the Basic Health Plan already factored into their base index rates for their 2017 projections. In recognition of these prior adjustments, the Department should direct 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 advance of the Marketplace adjustments, consistent with the directions provided to the carriers in advance of this year's prior approval process. 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 CareConnect 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

[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.

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).

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 to 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 memberships.

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.

[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/.

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

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 was 79 percent in both years). 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. <u>Carriers with small provider networks should do more to decrease rates.</u>

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 NorthShore's rate application are described below.

II. Specific issues in NorthShore LIJ CareConnect's Rate Application

HCFANY urges the Department scrutinize North Shore LIJ CareConnect's (hereafter "CareConnect") 2017 Rate Application, because CareConnect is requesting the second highest rate increase, at a 29.2 percent average, but has provided insufficient justification and evidence to support their request rate increase. While CareConnect did not redact key information like many other issuers, CareConnect's application, and Actuarial Memorandum in particular, fails to provide key information necessary to assess the reasonableness of their rate increases. The Department should not accept rate increases that fail to provide transparent and reasonable justifications supported by evidence, particularly when they will have a significant impact on consumers.

A. Insufficient Justification and Evidence in Actuarial Memorandum

[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/.

CareConnect provides little to no justification or evidence for many of their projected cost increases. Compared to many other plans, CareConnect's Actuarial Memorandum is extremely lacking in detail. CareConnect's Actuarial Memorandum fails to: (1) adequately disclose the methodology used to determine trend increase; (2) offer any explanation of estimated administrative costs; (3) provide evidence or justification of a dramatically different expected payment from the federal risk adjustment program; and (4) provide a justification for adjusting for the Basic Health Plan.

1. CareConnect failed to adequately disclose the methodology used to calculate trend increases.

CareConnect predicts a 2 percent trend increase, from 6 percent in 2016 to 8 percent in 2017. CareConnect merely states that this assumption is based on their projected provider contracts. The supporting evidence offered breaks out the trend increase into categories: inpatient hospital claims (IP), outpatient hospital claims (IP), professional claims (Prof) other medical claims (MD) and prescription drug claims (RX). CareConnect does not provide any information of the methodology used to determine the increases in these categories. In contrast, Independent Health, which is requesting a lower rate than CareConnect provides a description of the methodology used in determining trend increases.

2. CareConnect does not provide any justification or evidence for its administrative costs.

Care Connect merely states administrative costs are 9 percent across plans without any justification or evidence offered as to how CareConnect derived this number.

3. CareConnect does not provide justification or evidence for its assumption that it will receive risk adjustment transfer payments.

CareConnect has estimated that under the federal risk adjustment program, it will receive $10 pmpm transfer payment. CareConnect has explicitly rejected the $40 pmpm CareConnect would owe under the program as indicated by the interim CMS report. CareConnect has failed to provide any further justification or evidence for this assumption.

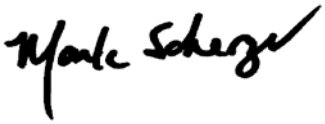
4. CareConnect is one of the plans that may be double counting morbidity changes caused by the Basic Health Plan.

CareConnect is requesting a .4 percent adjustment for the loss of health enrollees to the Basic Health Plan program. However, as noted above, CareConnect should have already received an adjustment for this same reason last year. This year, the carrier simply should have removed these members from its base rate calculation, in accordance with the Department's filing instructions. CareConnect provides no justification or evidence for why it failed to follow the directions of the Department to remove the claims of these members as it built the initial index rates.

It is difficult to determine the reasonableness of the rate increase requested by CareConnect given the lack of evidence and justifications offered in support of the rate increase application. Therefore HCFANY requests the Department to closely scrutinize CareConnect's rate increase application, and deny rate increases lacking sufficient justification and evidence. In future years the Department should consider rejecting CareConnect's rate request should it continue to file such limited public submissions. This does a disservice to a consumer friendly and transparent rate review process.

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

Sincerely,



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