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 – Oscar – INDIVIDUAL – OHIN 130551196

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

Health Care for All New York (HCFANY) submits the following comments relating to Oscar's proposed 18.4 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 Oscar'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 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 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

[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.

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 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

[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.

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 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.

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

[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/.

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. 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 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. 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 Oscar's rate application are described below.

II. Specific issues in Oscar's Rate Application

For the 2017 plan year, Oscar seeks an overall weighted average rate increase of 18.4 percent. HCFANY understands Oscar's need to increase premiums, particularly given that their stated 2015 medical loss ratio was 113.7;[9] they anticipate paying into the federal risk adjustment program; and expect a net loss of approximately 5.6 percent for 2017.[10] While Oscar has attracted a relatively healthy risk pool, their historically high MLR suggests they have been paying claims at a higher than expected rate. We understand that the rate increase is likely needed to ensure Oscar's long-term financial viability.

That said, HCFANY would like to highlight some issues from the company's rate application. HCFANY's biggest concerns are the lack of transparency in their filing and their high administrative costs. HCFANY would also like to highlight two positive aspects of Oscar's filing, a low medical trend estimate and a sizable downward adjustment due to a decreased network.

[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/.
[9] 2016 Decision Summary
[10] Exhibit 18, Line 37.

A. Oscar was one of the plans that failed to provide reasonable amounts of information in their filing.

Oscar is a notable example of the transparency problem described above. Oscar's original application redacted almost all useful information, including the following:

- Projection Factor (page 9);
- Credibility Manual Rate Development (page 10);
- Risk Adjustment Discussion (page 12);
- Medical Loss Ratio Tables (page 14);
- Index Rate Calculation (page 16);
- Calibration (page 17);
- Consumer Adjusted Premium Rate Development (page 18);
- Actuarial Value Pricing Values (page 20); and
- Membership Projections (page 21).

The redaction of that material made it nearly impossible to fairly evaluate Oscar's proposed rate increase and circumvents the public rate review process. HCFANY appreciates the Department's quick response to this concern, which eventually resulted in a more complete rate filing for Oscar. However, all carriers should follow the rules in filing their rate applications at the outset. When plans needlessly redact large amounts of information from their applications, it makes an already challenging process even less accessible to the public.

Further, Oscar's newly posted application still lacks detail that would help the public assess its request. For example, Oscar does not provide a breakdown of its administrative costs. This is discussed in more detail below, but is of particular concern because Oscar is requesting by far the highest administrative costs of all the filings this year. Another example is their 10 percent estimated increase in pharmacy prices. This may be reasonable, but there should be some narrative included in the filing that supports this adjustment.

B. Oscar's very high administrative costs are an outlier and should be scrutinized.

Oscar seeks a 28.7 percent adjustment for administrative costs. This is over 11 percentage points higher than the next highest carrier (17 percent for Affinity). It remains the largest request even after accounting for their expected 5 percent loss. Additionally, their request is 5.4 percentage points higher than their request from last year.[11]

Oscar cites a lack of economies of scale for its higher than average administrative costs.[12] Further, Oscar states in its 2016 actuarial memorandum, "Oscar anticipates an underwriting loss in 2016, generated as a result of having excess administrative expenses due to its startup position and low enrollment, and the need to have competitive premiums to

[11] 16.9 percent administrative costs excluding profit, Oscar's 2016 Rate Application, Actuarial Memorandum, at 14.
[12] 2016 Rate Application Individual On-Exchange Actuarial Memorandum, at 14.

attract enrollment and grow the business to cover the company's administrative expenses."[13] During 2016, Oscar experienced strong enrollment growth (from just over 32,000 members as of the 2016 rate filing[14] to just over 64,000 as of the 2017 rate filing).[15] Oscar should begin achieving administrative savings given that their membership has doubled over the past year.

Because there is so little detail in Oscar's filing, HCFANY cannot dispute that Oscar's administrative costs expectations are reasonable or justified. The absence of a substantive explanation is concerning given that Oscar is requesting much higher administrative costs than all the other plans. HCFANY is concerned that Oscar may be incorporating excessive marketing expenditures in its administrative costs and inappropriately seeking to recoup underwriting losses by inflating its administrative expenditures. DFS should carefully review Oscar's administrative cost estimate to ensure it conforms to New York's market standards.

C. **Oscar's medical trend estimate is one of the lowest**.

HCFANY commends Oscar's low medical trend adjustment. Oscar's estimate of 3.7 percent is the second lowest in the individual market filings. Oscar is anticipating very low increases in utilization, including no increase for in-patient care, 1.5 percent for outpatient, 1.5 percent for physician and other services, and only 0.4 percent for prescription drugs. HCFANY feels that these are reasonable expectations and in line with our comments above about national medical trend rates.

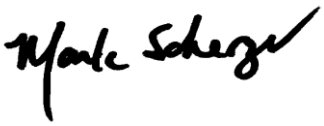
D. Oscar took the largest downward adjustment for provider network changes.

HCFANY appreciates that Oscar is requesting a 17 percent rate adjustment in accordance with their decision to offer a narrower provider network in plan year 2017.[16] Although Oscar does not provide an explanation for this downward adjustment, it appears to be related to Oscar's decision to drop New York Presbyterian and others from its provider network.[17] A reduction in the number of in-network providers may potentially burden its enrollees; accordingly, HCFANY believes it is appropriate to pass along the related savings to consumers.

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

Sincerely,

[13] 2016 Rate Filing Actuarial Memorandum, at 14 -15.
[14] https://myportal.dfs.ny.gov/web/prior-approval/oscar-ins-corp/ind-on-exchange-epo-ohin-130063471
[15] https://myportal.dfs.ny.gov/web/prior-approval/oscar-ins-corp/ind-bothx-epo-ppo-ohin-130551196
[16] Exhibit 18, Line 14.
[17] Tracer, Z, 2016, "Health Insurance Startup Oscar Narrows Hospital Networks to Compete," *Insurance Journal.* http://www.insurancejournal.com/news/national/2016/02/24/399545.htm.



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