Actors Fund ☙ Children's Defense Fund-New York Community Service Society of New York
Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority
Young Invincibles

July 7, 2016

Maria T. Vullo, Superintendent
Troy Oechsner, Deputy Superintendent for Health
John Powell, Assistant Deputy Superintendent for Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: Requested Rate Changes – CareConnect – Individual – 131036544

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

Health Care for All New York (HCFANY) submits the following comments relating to CareConnect's proposal 29.7 percent increase for their 2018 individual rates.[1] 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 CareConnect's rate application.

I. Market-Wide Issues

This year, the deliberations in Washington, D.C. about potential changes to the Affordable Care Act (ACA) complicate the process of determining the rates insurers will need in 2018 in order to pay claims and retain a reasonable margin for administration, profit, and/or

[1] HCFANY would like to acknowledge the invaluable assistance we had this year from Jay Angoff, of Mehri & Skalet, PLLC (www.findjustice.com), in the preparation of these comments.

reserves. Nevertheless, several factors indicate that individual market rate increases in New York State for the 2018 plan year should be relatively modest.

First, the U.S. Department of Health and Human Services (HHS) has promulgated two new regulations giving insurers more flexibility to restrict enrollment and to design policies with less generous benefits.

Second, insurers have now had over three years of experience in doing business on the New York State of Health Marketplace, and in adapting to the ACA's requirements. That experience, as well as the fact insurers have less pent-up demand and no longer have start-up costs should enable them to reduce costs.

Third, the size of the New York market means insurers do not need to incorporate additional amounts into the various assumptions they make to account for uncertainty resulting from data that are not fully credible.

With those factors in mind, HCFANY offers the following general observations that may have bearing upon the Department's analysis of issues common to all rate filings as it seeks to determine for each carrier rates that are not excessive, inadequate, or unfairly discriminatory.

A. The trend factor

Trend is the rate at which the insurer projects it must increase (or decrease) its rates due to underlying health care costs. Along with the health status of the insured population, it is one of the two factors that typically has the greatest impact on a proposed rate.

In assessing the reasonableness of a projected medical trend, HCFANY believes that the Department should consider whether a carrier's assuming a high trend factor increases the likelihood that it will accept unreasonably large provider price increases rather than negotiating rigorously with providers. In particular, the Department should not accept at face value insurer statements that are based on the assumption that the company is a passive price-taker, and cannot use its bargaining power to drive down underlying healthcare costs. To be sure, hospitals have substantial bargaining power — some to such an extent that they are commonly characterized as “must have” hospitals. At the same time, however, many doctors and hospitals cannot afford not to be in the networks of the major carriers. By disapproving rates to the extent that they incorporate unreasonably high trend assumptions, the Department can give both the insurer and the providers it contracts with an incentive to manage costs so that they do not exceed what the Department has approved. HCFANY therefore believes that the rate approved by the Department should be based on a lower trend factor than the carrier has assumed to the extent that the Department concludes that the carrier has not sufficiently used its bargaining power to drive down costs.

Moreover, the Department may wish to scrutinize trend factors exceeding 5 percent particularly closely. That is because the Milliman actuarial firm, which in its Milliman Medical Index (MMI) has been calculating the annual increase in healthcare costs for each of the last 15 years, has determined that medical trend has been steadily decreasing. In fact, medical trend hit new lows in both 2016 and 2017: 4.7 percent in 2016, and 4.3 percent for 2017.

In addition, because the MMI trend is the trend Milliman found for "an average employer-sponsored PPO plan," trend in New York's predominately in-network only individual market could be even lower than the 4.3 percent found by Milliman. First, Milliman explains that "employers and employees have been subsidizing other markets for many years," because the plans insurers sell to employers are paying higher rates to providers than are individual plans. Trend for individual plans therefore may reasonably be expected to be lower than trend for group plans. Second, because PPO plans provide some coverage when the insured sees an out-of-network provider, and thus have less control over their costs than do carriers offering only in-network coverage, New York's mostly closed-panel plans may reasonably be expected to have a lower trend than a trend based on PPO data, as Milliman's is.

In determining a reasonable rate increase, therefore, the Department may wish to disregard the assumed trend factor to the extent it substantially exceeds the Milliman-determined trend.

Drug trend is a component of overall medical trend. It accounts for 17 percent of overall trend, according to Milliman. Drug trend is higher than other medical trend, but according to both the MMI and a recent Blue Cross Association study of drug spending on Blue Cross enrollees since 2010, it is not nearly as high as some carriers are projecting. The Blue Cross study found that spending on drugs has been increasing by 10 percent annually since 2010, and Milliman found drug trend to be 8 percent. While both numbers are substantially higher than trend for non-drug medical spending, this is the second year in a row that drug trend, like non-drug medical trend, has decreased. According to Milliman, a few years ago drugs became available that cured hepatitis C but at a cost of almost $100,000, which drove large increases in drug trend. Milliman explains, however, that those increases will not continue to the same extent because many hepatitis C patients have now been cured. In addition, Milliman notes that many drug company CEOs have "taken the price hike pledge" to keep price increases below 10 percent, and that some pharmacies are reducing drug prices so they can participate in preferred pharmacy networks and thereby increase their sales of non-pharmacy products.

In view of the above, HCFANY urges the Department to require carriers to submit robust support for any assumed drug trend exceeding 10 percent before approving any rate increase incorporating such a trend.

B. <u>Morbidity</u>

The health status of the insured population in the market — morbidity — can also have a very substantial effect rates. Trend and morbidity are two separate concepts. Trend is the change in health care costs everything else equal, while morbidity measures the increase in costs due solely to the change in the market's health status. However, there is clearly a potential for double-counting because trend includes both the change in unit costs and the change in utilization, and it is difficult to separate out the extent to which utilization changes while health status remains constant from the extent to which utilization changes because health status becomes less favorable. The potential for double counting is particularly great if the insurer assumes both a high trend factor and a high morbidity factor.

In estimating rate needs, some carriers have assumed that morbidity will remain unchanged in 2018, while others have assumed that it will be less favorable in 2018, i.e., that 2018 enrollees as a group will be less healthy than were 2017 enrollees. The Department should use the same morbidity assumption with respect to all carriers in determining the rates it will approve. Morbidity measures the change in health status of the market as a whole, regardless of the assumption any given carrier makes as to morbidity.

In addition, the Department may wish to also consider factors weighing in favor of morbidity improving in 2018. Insurers have strongly argued that individuals with the greatest need for insurance — those with pre-existing conditions — are more likely to sign up for insurance than people in standard health. Those people have now had four years to sign up. It is therefore reasonable to assume that most individuals with health conditions have signed up, and that morbidity is likely to improve as time goes on. In addition, the individual market pool can reasonably be expected to be healthier as time goes on because pent-up demand will have been satisfied: the previously uninsured with health conditions who became insured at their first opportunity to do so will have obtained care for problems they avoided getting care for when they were uninsured. They may still have higher-than-average expenses, but not to the extent that they did when they first enrolled. This is especially true in New York, where the individual market enrollment has increased from an all-time low of 19,000 in 2013 to over 360,000 in late 2016.

More significant than any of the above, however, a new HHS rule and CMS guidance, opposed by advocates and New York State alike, include several provisions that the industry has strongly argued will improve the health status of the individual risk pool in 2018. They include:

1. A shorter open enrollment period

The new HHS Market Stabilization Rule shortens the open enrollment period in all states from 90 days to 45 days: from November 1 through January 31 in 2016 to November 1, 2017 through December 15 in 2017. Insurers have argued that this will allow them to collect a full year's premium from all enrollees for the first time, and that it will reduce the likelihood of adverse selection by consumers who learn they have health problems in December and January:

people could no longer buy coverage after the new year started that would pay for a condition they discover between December 15 and January 31. This can benefit insurers in two ways. First, it enables them to avoid paying for anyone who has not bought or renewed coverage by December 15 and has a serious illness or injury between December 15 and January 31. Second, if consumers know that they must enroll by December 15 to avoid the possibility of being personally responsible for their health care costs, the number of healthy insureds signing up is likely to increase.

2. Limiting special enrollment periods (SEPs)

The HHS Market Stabilization Rule also makes it more difficult for consumers to sign up during Special Enrollment Periods (SEPs). For example, it requires consumers applying during an SEP to verify their eligibility. Up until now, individuals seeking to apply during an SEP could simply attest to their eligibility, thus allowing people who had just discovered a serious health condition to attest that they were eligible even if they were not. In addition, the Rule prohibits individuals who add a dependent during an SEP from obtaining more comprehensive coverage during the SEP. And the Rule also makes it easier for insurers to reject people during SEP's on other grounds. It allows insurers to reject those who have lost Minimum Essential Coverage because they did not pay their premium, unless they pay back those premiums. It allows newlyweds to buy coverage during an SEP only if one spouse had Minimum Essential Coverage or had lived abroad at some time during the previous 60 days. And it requires consumers claiming "exceptional circumstances" enabling them to buy during an SEP to meet a higher standard than in the past and to submit supporting documentation.

The Rule's provisions restricting special enrollment expressly apply only to the federally-operated Exchanges. Nevertheless, HHS encourages states to adopt those restrictions. To the extent the New York Marketplaces adopts these rules — and it is widely believed to have done so — it should ensure that savings resulting from those restrictions be reflected in the morbidity assumption used to determine the rate.

In summary, all the above factors can reasonably be expected to improve morbidity. The Department should consider all those factors, as well as those that could worsen morbidity, in determining a reasonable market-wide morbidity assumption to be incorporated into each rate filing.

C. The impact of cost-saving provisions

Insurers typically increase their rates to reflect the cost of implementing quality improvement measures and new technology, but rarely reduce their rates to reflect the cost-savings that result from such measures. Notably, New York State has engaged in a series of efforts to encourage value based payments and expand the use of primary care and medical homes. These efforts should be factored into the Department's analysis of the carriers' requests.

In addition, quality improvement and new technology cost money, but they should save more money than they cost: if they don't, why implement them? Relatedly, insurers may narrow their networks, negotiate discounts with providers, and take steps to limit utilization, but they rarely assume any savings resulting from these initiatives in their rate filings.

Importantly, Exhibit 18 to the rate filing includes four lines on which an insurer should reflect savings resulting from actions it has taken which may reasonably be expected to reduce costs. Those lines are as follows:

1. Line 14 — Marketwide adjustment for changes in provider network. Insurers have argued that narrow networks reduce premiums and improve quality by forcing providers to compete to be in the network. Insurers have consistently maintained, with evidentiary support, that by narrowing their networks they can reduce their costs. Nevertheless, insurers typically refuse to recognize any such savings in their rate filings, since the factor they use for changes in provider network is usually 1.00.

2. Line 15 — Marketwide adjustment for fee schedule changes. Although carriers do not make their fee schedules public, when they guarantee providers a certain volume of business for participating in their network the standard quid pro is for providers to accept reduced fees. Yet insurers usually include a 1.00 factor for fee schedule changes.

3. Line 16 — Marketwide adjustment for utilization management changes. Utilization management--including both providing needed care more efficiently, and discouraging people from obtaining unneeded care — by definition reduces costs. Despite this, insurers routinely use a 1.00 factor for utilization management changes.

4. Line 17 — Marketwide adjustment factor for impact on claim costs from quality improvement and cost containment activities. By definition, cost containment activities contain costs. The purpose of quality improvement activities is to improve quality so that as a result of improvements in quality costs are contained. Again, insurers routinely use a 1.00 factor for quality improvement and cost containment activities.

With respect to all four of above cost-saving measures, unless the insurer can make a compelling case that its initiative is not saving money — in which case it probably should not be implementing it at all — the Department should assume a factor of less than 1.00 in calculating an appropriate rate change.

D. <u>The impact of lower actuarial values</u>

The Market Stabilization Rule allows insurers to sell plans with lower actuarial values at each metal level. Under the original HHS rule implementing the statutory requirement that insurers sell plans with Actuarial Values (AV) of 60 percent, 70 percent, 80 percent, and 90 percent (known, respectively, as Bronze, Silver, Gold, and Platinum plans), the AV of any metal

level plan could vary by plus or minus 2 percent. Thus, for example, an insurer could sell a plan with an AV of between 68 percent and 72 percent as a Silver plan. The Market Stabilization Rule increases the allowable downside variation for all metal-level plans to -4 points, while keeping the upside at +2 for Silver, Gold and Platinum and raising the upside for a Bronze plan to +5. These provisions expressly apply only to federally-operated Exchanges, but HHS encourages state Exchanges to adopt them too. To the extent that the New York Marketplace permits carriers to do so — as is widely believed — the Department should ensure that the resulting savings be reflected in the approved rate.

E. The impact of the higher 2018 out-of-pocket limit

The new HHS Benefit and Payment Parameters Rule contains a provision increasing the maximum out-of-pocket (OOP) limit by 2.8 percent, to $7,350 for individual coverage and $14,700 for family coverage. The rule expressly applies in all states, regardless of whether the federal or state government operates the Marketplace in the state. Notably, insurers almost always include a factor that increases the rate for so-called "deductible leveraging"— trend increasing while the deductible remains constant, thus increasing the effective trend for the carrier. On the other hand, insurers do not include a factor that reduces the rate for an increase in the OOP maximum, which can potentially reduce the effective trend, since insureds subject to the new higher OOP maximums pay for more of that trend. HCFANY urges the Department to require that the rates it approves incorporate the effect of the new higher OOP maximum.

F. Administrative expenses

Although a few carriers assume that their administrative expenses will remain constant or decline slightly in 2018, the majority of carriers (9 out of 13) assume they will increase. Such an assumption would appear to be unreasonable, for three reasons. First, administrative expenses can reasonably be expected to decline as insurers become more familiar with doing business on the Exchange, and they have now had three and half years of experience with the Exchange system.

Second, insurers have traditionally had to heavily market and establish their own broker networks to sell insurance to the individual market. With the Marketplace system, however, they need do neither, since the Marketplace allows them to reach all their potential customers without establishing a broker network. As the New York State of Health Marketplace has become institutionalized, carriers are dropping reliance upon broker commissions or downwardly adjusting them.

Third, the extensive coverage the media give to the ACA, whether positive or negative, continues to increase public awareness of the law and of its requirement that people have insurance. As a result, insurers can spend less on marketing than they otherwise would.

The Department therefore should not approve a rate to the extent that it includes an increase in administrative expenses. In addition, the Department may wish to consider requiring that rates for 2018 reflect lower administrative expenses than 2017 rates.

G. Underwriting profit

The higher a carrier's underwriting profit, the greater the extent to which it can increase its surplus. To be sure, insurers should hold surplus sufficient to ensure that even under the most pessimistic assumptions they will be able to pay all claims. However, beyond some point additional surplus is unnecessary to protect policyholders. In for-profit companies, such excess surplus redounds to the benefit of the shareholder/owners, since their stock reflects the value of all the company's surplus. Non-profits, however, have no shareholders. They owe a duty not to shareholders but either to the general public or their policyholders, neither of whom benefit from surplus that exceeds the amount necessary to protect policyholders. There is therefore a substantial argument that non-profit insurers should not be permitted to include an underwriting profit provision in their rates if their surplus exceeds the level necessary to protect policyholders.

What is that level? The Blue Cross Association requires Blue plans to have a minimum risk-based capital (RBC) ratio — the ratio of the company's year-end surplus to its Authorized Control Level surplus — of at least 375 percent, and has historically considered a plan to be a strong Blue if its RBC ratio exceeds 500 percent. It has never established a maximum surplus standard. Neither has the New York Department of Financial Services, or the NAIC. However, in 2005 the Pennsylvania Department of Insurance issued an order establishing a 550 percent RBC level as that at which a non-profit Blue plan may not include an allowance for "risk and contingencies" in its rate filings, and establishing the 950 Percent RBC level as presumptively excessive.

That order is not binding in other states. Nevertheless, HCFANY believes that the Department should consider whether there is some RBC level in the 550-950 percent range at which a nonprofit plan should not be permitted to include an underwriting profit factor in its rates. Establishing such a level is important because a high underwriting profit factor gives the insurer an incentive to pay providers higher rather than lower prices, since the higher those prices are, the larger the base to which the underwriting profit percentage is applied.

H. Special consideration regarding very high proposed rate increases

At some point, proposed rate increases become counter-productive for the carrier: they become so high that they drive away the healthy risk in the pool, thus further worsening the health status of the pool and requiring even greater increases in order to pay for the increasingly unhealthy pool. A lower rate increase, on the other hand, will bring in more relatively healthy risks.

To be sure, a relatively low rate increase may well not be sufficient to enable the carrier to meet its profit targets. A huge rate increase is, however, almost certain to accelerate the collapse of the system. The Department therefore may wish to reduce very high proposed increases in order to avert an even worse case situation than that used by the insurer to justify its increase.

I. Distribution of the increase by metal level

Some carriers are seeking to implement substantially greater percentage increases for the more comprehensive plans — gold and platinum — than for the less generous silver and bronze plans. This could have the effect of driving the healthier people out of the gold and platinum plans, thus requiring even higher rates for those plans in the future. The Department should therefore satisfy itself that the manner in which the insurer distributes the total increase across metal levels will not unduly disadvantage high-cost enrollees, or lead to a pricing spiral for platinum and gold coverage.

J. Special considerations regarding the size of the carrier

It may make sense for the Department to be more solicitous of a small insurer with a high proportion of individual business than of a large insurer with relatively little individual business. That is because the consequences of the Department being wrong in substantially reducing a rate increase are relatively insignificant for a large insurer with relatively little individual business, but much more significant for a small insurer with mostly individual business. So, for example, if a small insurer with primarily individual business assumes a higher-than-average trend or expense or profit factor, the Department may wish to consider the more serious effect of failing to recognize risk and give the carrier's judgments greater deference. On the other hand, in the case of a large carrier with relatively little individual business, HCFANY believe the Department should be less deferential to estimates of risk that deviate from national norms. The consequences for those insurers are less impactful if the Department is wrong. Those large insurers also can reasonably be expected to use bargaining power to reduce trend and are able to spread costs over a wider base to reduce expense factors.

II. Specific Issues in CareConnect's Rate Application

HCFANY's would like to offer the following specific comments regarding CareConnect's 29.7 percent requested rate increase. CareConnect's request raises concerns for HCFANY because it is so large and because it will affect so many customers. The company projects over 30,000 members for 2018, the third largest market share in New York's individual market. The company's request is above average for New York's individual plans, which was 20.9 percent. This is on top of a very large (and higher than average) increase of 29 percent for its 2017 rates.

CareConnect's members may not be able to manage a second year of double-digit rate increases. HCFANY is concerned that such large rate increases will become a self-fulfilling prophecy. Members who have less serious health needs and who can change insurers without disrupting their care may choose a different, cheaper plan. This would lead the company into a spiral where its risk pool gets worse and worse, and it is forced to continually raise rates.

While CareConnect appears to have lost money for several years in a row (claiming medical loss ratios of over 100 percent for 2014, 2015, and 2016), there are areas in which the company could reduce costs in order to protect their customers. HCFANY urges the Department to carefully consider the following issues in CareConnect's application: (1) a very high medical cost trend assumption; (2) high administrative costs; (3) a low medical loss ratio goal; and (4) the company's claim that the risk adjustment program is the main reason it made such a large request.

A. CareConnect's medical trend assumption is too high.

CareConnect assumes a trend of 7.0 percent for 2017 and 9.0 percent for 2018. That assumption is unreasonable for three reasons. First, both 7 percent and 9 percent are far higher than the 2017 Milliman Medical Index trend of 4.3 percent. Second, the rate of increase in health care costs is trending downward, not upward, according to Milliman and others.[2] If CareConnect is assuming a different trend for 2018 than for 2017, that trend should be lower, not higher, than the 2017 trend. Third, and most fundamental, CareConnect is a provider-owned plan created by Northwell Health (formerly known as North Shore Long Island Jewish Hospital system). It therefore has more control over its costs than an insurer-owned plan. The Department should therefore at a minimum disallow CareConnect's trend factor to the extent that it exceeds the industry average.

B. CareConnect's administrative costs are too high.

Care Connect assumes administrative expenses of 18 percent. This is far higher than the average of New York's individual market carriers. In addition, as a provider-owned plan CareConnect should have administrative expenses that are lower, not higher, than the industry average, since it is dealing with its own providers. Further, CareConnect has more members than most other carriers among whom to spread its administrative costs. At a minimum, therefore, the Department should disallow CareConnect's administrative expense assumption to the extent that it exceeds the industry average.

C. CareConnect's medical loss ratio goal is lower than most other New York carriers and much lower than anything it has achieved before.

[2] *See, e.g.,* Aon, 2017 Global Medical Trends, *available at*: http://www.aon.com/attachments/human-capital-consulting/2017_GB_Trends_brochure_20170105.pdf

CareConnect appears to have had medical loss ratios of over 100 percent for three years: 110 in 2014, 116 in 2015, and 113 in 2016. For 2018, the company expects a medical loss ratio of 82, the state minimum. HCFANY believes that carriers should not treat the state required minimum as a goal to aspire to, but rather as a floor. The minimum medical loss ratio is a backstop to protect consumers, but carriers can reasonably be expected to perform better. Only one other carrier set a goal as low as did CareConnect.

Additionally, it is a big jump for CareConnect to go from a medical loss ratio of 113 percent to 82 percent. If CareConnect set a higher medical loss ratio goal, it could reduce its rate request and still move towards profitability.

D. CareConnect's claim that the federal risk-adjustment program is the primary driver of its 30 percent rate increase request is unpersuasive.

In its Narrative Summary, CareConnect argues that the federal risk adjustment program is largely responsible for its seeking a 30 percent rate increase, and that but for its risk adjustment liability it would be seeking "a relatively small rate increase for 2018."[3] To the extent that that statement is accurate, risk adjustment has a much smaller effect on CareConnect's individual business than it does on its small-group business: CareConnect's projected 2017 risk-adjustment payment for its small group business equaled almost 49 percent of its 2017 small group revenue, while its individual risk-adjustment payment equaled 17 percent of its individual revenue.

In addition, because of the risk-adjustment changes ordered by the Department for 2017, CareConnect's risk-adjustment payment for 2018 will be substantially less than it was in 2017. While that payment is not immaterial, CareConnect's unreasonably high trend and unreasonably high administrative expense assumptions and its unreasonably low 82 percent medical loss ratio target, are the major factors responsible for CareConnect's requested 30 percent rate increase for 2018.

An unusually large number of consumers submitted public comments regarding CareConnect's proposed rate increase. These consumers share HCFANY's concern that CareConnect's requested rate increase is too large and that the company's explanations are too vague. More specifically, these consumers question the fact that CareConnect cannot better control trend as a provider-sponsored entity and are unpersuaded by its efforts to blame the risk adjustment process for its rate increase. Here are some examples:

> The rate increase request of 31.69 percent is astounding and must be denied. The first justification for the increase in the notification letter indicates increased health care costs, partly because improvements in medical technology tend to be expensive, as are many of the newest drugs. DFS should require the company to provide an itemized list of such improved technology as well as newest drugs (that are covered under the plan) and

[3] CareConnect Narrative Summary at 1.

include the itemized increased costs year of year that can be directly attributed to such technology and new drugs. The second justification for the increase has to do with the federal Risk Adjustment program. The letter is silent on how much of the increase is federally mandated. If the purpose of the Risk Adjustment program is as stated in the letter: intended to help keep the health insurance market stable and ensure competition this is placing an undo burden on those of us that have opted to purchase health insurance from CareConnect. The cost associated with this program should be shared across all residents of New York whether or not they have purchased health insurance. Furthermore the letter states that the money is 'put aside' - there is no mention of potential rebates should the full amount 'put aside' not be consumed. The annual increases far surpass the rate of inflation as well as my ability to generate additional income to pay for same. We need relief.

I have just been advised that Care Connect is requesting an outrageous 26.35 percent premium increase….The increase is outrageous, and Northwell now represents a monopoly in Nassau county. NY State should protect residents like me and implement a 25 percent reduction not increase. Other states have premiums far below those in NY where physicians and hospitals are making millions in profit.

Further to my previous email regarding CareConnect's request for a 33 percent premium increase for 2018. Please note that this request comes only 6 months after finalizing the 2017 premiums. How is it possible that CareConnect has experienced a 33 percent rate of inflation within 6 months when the actual inflation rate is running under 2 percent annually. DFS needs to require an independent accounting. CareConnect provides no data, no hard facts. Their 33 percent increase is due to new drugs, advances in medical technology and the Risk Adjustment program and they provide zero numbers to substantiate any of the above. Their request lacks any credibility

CareConnect sent a letter that it has requested a staggering 32.73 percent rate increase for 2018. How is it possible that their costs have increased by this amount only 6 months after the start of the year? They give no credible accounting for the proposed rate increase except to indicate that a portion of the premium increase is for the Risk Adjustment Program and laying the blame on NYS. NYS DFS should demand an outside audit of CareConnect's questionable cost estimates. NYS needs to protect consumers from price gouging by for-profit insurance companies. If this rate increase is allowed to stand then the DFS is not doing its job and Governor Cuomo should shut down the agency.

I am a retired New Yorker not yet eligible for Medicare. I've purchased an individual medical insurance policy from Northwell Health in Nassau County. In 2016 my premium increased by 30 percent from $500 to $649. Now Northwell is requesting an additional 26.4 percent increase which means my premium will increase to over $820 per month from $500 two years ago. The lack of competition in Nassau County (Northwell has tied

up all the physicians) and the outrageous sums paid to hospitals and physicians are resulting in usurious increases in premiums….

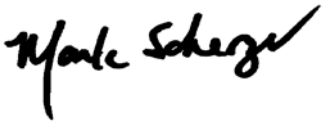
I wrote you a letter last year when they raised the premiums 21 percent. you wrote me a cock and bull story why they should get the raise. Now they want 31 percent raise. Who are you? On which side of the problem are you?. Do you care about us the working people, or you on the side of the CEO Mr. Dowling getting more than 9.1 Million dollars last year. Do not allow more than a raise in living wage which is about 2 percent, or they will keep on spending our hard earned dollars. If you cannot achieve this we the people will replace you. I personally will partake in that assignment. Respectfully ,

With the subsidy, I currently pay $474/month for Care Connect health insurance. My closest hospital, Phelps Memorial, participates with them, but their anesthesiologists, radiologists and pathologists do not. If I would need a procedure where one of those specialists was needed, I would have to drive 20 miles to Montefiore. I don't think this illusory coverage deserves a rate increase of 29.04 percent. I am struggling to pay the $474/month. I can't use the local hospital. If I don't get a subsidy next year, I could end up paying $1000/month for health insurance.

I am a practicing attorney in this state, and know full-well the game of financial chicken that is played out between insurers and hospital paymasters, with the constituents left to foot the bill. The increasing cost of healthcare is an illusion. Insurers demand discounts before they will put a provider in-network such that, in the end, they pay fractions of the invoiced amounts, and hospitals arbitrarily charge exorbitant rates well above value-for-services knowing and intending that they will only collect pennies on the invoiced dollar. Both parties publicly weep and gnash their teeth about how unfairly they are treated, and yet, somehow, the healthcare industry remains one of the fastest growing and most profitable in the country. In fact, the only party consistently harmed in this standoff is the individual insured. So, I write now not only to oppose this outlandish, unsupported rate hike proposed by CareConnect, but to oppose all the other, similar ones like it. This race-to-the-top of the billing potential, fueled by insurers preying on the average person's need for healthcare coverage for their self and their family, and sponsored by the State through the individual mandate, cannot continue. The State of New York's healthcare system requires a total overhaul, including regulation requiring the disclosure of hospital pricing guidelines and strict control over hospital/insurer discounting practices in order to disincentivize the current financial feeding frenzy which leaves insurers and providers fat and, more often than not, the average citizen bleeding, but that is a statement on the War. As to this Battle, specifically CareConnect's proposed, usurious rate hike, I, a tax-paying, voting constituent, comment that it must not be permitted.

HCFANY urges DFS to carefully review CareConnect’s application. Thank you for your attention to these comments. Please contact us with any questions at adunker@cssny.org or 212-614-5312.

Sincerely,



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