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, 2017

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 – Fidelis – Individual – 131022623

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

Health Care for All New York (HCFANY) submits the following comments relating to Fidelis Health Plan's proposed 8.5 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 the application submitted by Fidelis.

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

[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.

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. Morbidity

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. <u>A shorter open enrollment period</u>

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. <u>Limiting special enrollment periods (SEPs)</u>

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. The impact of lower actuarial values

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 Fidelis' Rate Application

HCFANY would like to provide the following specific comments on Fidelis' request for an 8.5 percent rate increase across all plans. Fidelis is one of the largest carriers in the New York market. In 2017, it covered 58,935 consumers across eight regions, including Albany, Buffalo, Long Island, Mid-Hudson, New York City, Rochester, Syracuse, and Utica/Watertown. Fidelis offers no non-standard products, and is priced at the low end of the market.

The company's application includes quite a few positives for members. Its request is one of the lowest and is much lower than the statewide average request for a 20.5 percent increase. Fidelis has a history of making smaller requests than average. The company also has a substantially lower expense ratio (7.7 percent) than other New York carriers and should be commended for lowering it even more since last year. Finally, Fidelis has set a higher goal for its 2018 medical loss ratio than any other carrier. This suggests that the company is responsible with the premium dollars it receives from members. Nonetheless, HCFANY recommends a close examination of the company's application. Fidelis has the largest number of enrollees in the individual market and so its decisions affect the most New Yorkers.

Last year, the Department approved Fidelis for a 3 percent larger premium increase in 2017 than it initially requested: 11.6 percent approved versus 8.13 percent. HCFANY urges the Department to refrain from approving increases that are larger than requested as a matter of public policy, in the interests of consumer savings and the need for a statewide plan to reduce medical costs.

A. <u>Fidelis expects significantly more customers this year but argues that its risk pool will be worse.</u>

Fidelis projects a 23 percent increase in enrollment in 2018, up to 72,778 from 58,000 in 2017.[2] However, Fidelis alleges that there will be an overall decrease in marketplace enrollment, with sicker enrollees, to help justify their rate increase. As a result, according to Fidelis, the overall statewide pool will be between 4 percent and 5 percent more expensive in 2018.

[2] *See* Fidelis Actuarial Memorandum at 2.

However, Fidelis provides no support for this assumption. Should it be true, it would need to be applied equally across all carriers, yet not all carriers made this assumption in their applications. At any rate, it is unclear why fewer people would buy insurance on New York's marketplace next year when the evidence indicates that 2017 broke all enrollment records, in spite of the current high level of uncertainty amongst the public.

HCFANY asks that the Department review this claim in comparison to what other New York carriers have said about the statewide pool for next year.

B. Fidelis has a history of MLRs that are lower than the state allows.

According to Exhibit 13a, Fidelis has an MLR of 74 percent in 2014 and 78 percent in 2015. When the company was making its rate requests for 2017, it projected that the 2015 MLR would be 84 percent for 2015. There is no explanation of why the company's projection was off by six percentage points, enough to make it appear that it would meet state MLR requirements when in fact it now appears the company did not meet those requirements.

In this year's application, Fidelis expects that its MLR for 2016 was 93 percent but provides no discussion about why it expects such an increase. HCFANY urges the Department to carefully review the company's MLR claims. It would be inappropriate to allow another increase if Fidelis owes rebates to customers for not meeting MLR requirements.

C. Fidelis is asking for a higher profit than most carriers.

The company's request for a 2.34 percent profit is the second highest of all the applications and is higher than Fidelis has requested in the past. Almost all other carriers are using 2 percent. The requested profit is also higher than Fidelis has used in past years. In the documents available to the public from the Department's website, Fidelis does not explain this higher than typical request. However in its Actuarial Memorandum for HHS, in discussing this 2.34 percent factor Fidelis says that "a contribution to surplus is necessary as under New York Department of Health rules, Fidelis is expected to maintain a contingency reserve of 12.5 percent of revenue." If without a 2.34 percent underwriting profit Fidelis would be unable to maintain that 12.5 percent contingency reserve the Department should allow it; otherwise, the Department should disallow the .34 percent by which Fidelis' underwriting profit factor exceeds the industry norm.

D. The company's medical trend projection is higher than the 4.3 percent projection from the Milliman Medical Index without adequate explanation.

Fidelis seeks a medical trend of 5.3 percent. While this request is below average for New York, it is below average in a market in which almost every carrier has requested higher than expected trend without explanation. In light of the Milliman Medical Index trend estimate of 4.3 percent, HCFANY urges the Department to require Fidelis to provide a more detailed explanation of its strategy for managing medical trend.

E. Fidelis does not provide enough detail in its application for the public to ascertain whether it has appropriately accounted for network changes.

Fidelis includes provider network and fee schedule changes within its trend factor. The Department should require Fidelis to demonstrate the basis for these assumptions. Fidelis' Actuarial Memorandum states that: "All changes in provider network and fee schedule levels were included in the claims trend."[3] Including such changes in trend rather than as separate line items on Exhibit 18 could artificially distort underlying trend if such changes have been made recently, given that Fidelis is using 2016 as the base year and calculating the 2018 rate increase by using two years of trend from 2016. Fidelis should separate out the underlying trend and use factors on Lines 14 and 15 that reflect the changes it has made in its provider networks and fee schedules.

On page 5 of its Actuarial Memorandum Fidelis notes that it is not including deductible leveraging and changes in deductibles, co-payments, and co-insurance in underlying trend, but is recognizing them as separate factors. That makes sense — it avoids distorting underlying trend — but Fidelis does not follow this same principle when it incorporates changes in fee schedule and provider network into underlying trend, as described in paragraph 1.

F. Fidelis takes no downward adjustment for its cost containment and quality improvement efforts.

Fidelis has made efforts to improve the effectiveness of its network, but does not make a downward adjustment to account for these efforts. Fidelis' Actuarial Memorandum states that "No adjustment was made on claims costs for quality improvement and cost containment initiatives."[4] That statement is difficult to square with its statement on the second page of its Narrative Summary that it is implementing initiatives "for improving health, including consumer education and web-based consumer support tools, promotion of wellness, and programs for managing chronic and complex medical conditions." Those initiatives, if implemented competently, necessarily reduce costs. Fidelis should therefore use a factor of less than 1.00 on Line 17 of Exhibit 18.

G. Fidelis incorporates investment income into its expense ratio, which could be misleading.

On page 3 of its Actuarial Memorandum Fidelis says its administrative costs are 7.66 percent "net of investment income." Reported administrative expenses should not include an offset for investment income. This makes it harder to judge whether Fidelis is doing all it can to keep its administrative costs low.

HCFANY urges DFS to carefully review Fidelis' application. Even a request that is relatively small compared to other New York plans can be a hardship for consumers, as

[3] Fidelis 2017 Actuarial Memorandum at 2.
[4] Fidelis 2018 Actuarial Memorandum at 2.

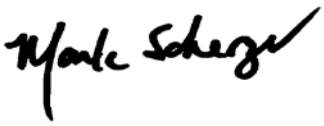
evidenced by the following comments submitted by Fidelis members to the Department's website:

> I received a letter stating that they are looking to increase my monthly premium from $367.04/month to $415.04/month. No mention of deductible rising, but it did last year with no warning. As a single working class woman I can truly not afford this increase. With the way the APTC is set up I do not qualify for any subsidies even though I only make a fraction more of what is considered subsidy worthy. My yearly salary is just over $50,000/year with no benefits and after I pay my 30 percent in taxes, rent, transportation, food, and household expenses I honestly can barely afford my current premium. If the rate increase is approved I don't know how I'll pay it. And I certainly won't even have the funds after paying the premium to pay for any of the doctor's services since the bronze plan doesn't cover much. So, I urge you not to approve this premium increase. And perhaps, please enlighten me as to ways that I could procure more affordable healthcare. It is very frustrating as a tax paying, working class American to feel left behind in the world of healthcare.
>
> Not only were premiums just raised for my husband and I in 2017 (Fidelis bronze metal plan), our deductible was also raised… The deductible as it stands is much higher than anything my husband and I will ever meet within the year and has been a huge deterrent in actually using our benefits. I myself had to pay out of pocket a significant amount to cover the bloodwork my primary care physician ordered for my annual physical (preventive care). In my opinion, fear of going to the doctor to avoid fees on top of an already significant monthly premium will only contribute to a more sickly population in the long run. To now request an additional premium increase ($62/mo personally) would place more financial strain on families, discourage rather than encourage individuals to use their benefits, or worse, cause those already insured to drop their insurance…
>
> I only go to the doctor for wellness appointments. My husband goes to a specialist 4 times a year and they only take off $90 per appointment because we use an in-network doctor. We will never meet the deductible unless we pay in $16,200 each year… We pay them $8,100 a year in premiums and they are paying out nothing, because we never meet our deductible…. The middle class is stuck paying for the rich to get richer and the poor to be safer, while we struggle.
>
> I am on their least expensive plan (bronze), because it is all I can afford, however they are proposing to increase the monthly premium from $367.04 to $415.04. That is nearly a 12 percent increase, which is more than five times the general rate of inflation. It's outrageously greedy…
>
> I was forced to switch to Fidelis because Emblem Health Platinum plan rates had skyrocketed. Now, I am in the same position… It is self-defeating to have premiums going up along with copays, etc… I don't qualify for subsidies. You need to raise the limit of what a person earns and allow more people to qualify for them. You need to keep

the premiums low… those who need health care coverage are going to be returned to a place of despair and hopelessness and be uncovered.

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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