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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 ☞ Young Invincibles

July 1, 2019

Linda A. Lacewell, 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 – CDPHP – CAPD 13198248

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

Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. HCFANY believes that the public rate review process is a vital consumer protection. We are grateful for the opportunity to submit comments and encourage consumers all over New York to do the same each year.

The comments below first address concerns about the market as a whole and second offer comments on the 7 percent increase requested by the Capital District Physicians Health Plan Inc. (CDPHP).

I. Market-Wide Conditions

A. State Action is Needed to Continue Increasing Enrollment in the Individual Market

New York has successfully cut its uninsured rate in half since the implementation of the Affordable Care Act (ACA), from 10 percent to 5 percent.¹ This has been in part due to New York's robust embrace of the ACA, including the proactive and aggressive steps taken by State leaders to counter recent federal threats to the individual insurance market. Those steps include codifying the ACA into state law, continual efforts to create a seamless enrollment process, and

¹ New York State of Health, 2019 Open Enrollment Report, May 2019,
https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202019%20Open%20Enrollment%20Report_0.pdf.



investment in in-person assistance. Even though enrollment in Qualified Health Plans has declined in other states, on the New York Marketplace enrollment in Qualified Health Plans has increased three years in a row.² Experts attribute the enrollment increases seen in 2018 and 2019 to this leadership.³

	On-Exchange	Off-Exchange	Total	Percent Change
2017	223,705	124,004	347,709	
2018	237,191	91,593	328,784	-5.4%
2019	254,634	71,272	325,906	-0.9%

HCFANY urges the state to carefully review the carriers’ 2020 submissions and reject any increases based on the alleged degradation of the individual market—which simply did not happen. Each year, the carriers have incorrectly predicted eroding market conditions to justify large rate increases (most recently due to the elimination of the individual mandate tax penalty). And each year, these predictions do not materialize. It is true that there was a slight drop-off in off-exchange enrollment last year. However, an increase in on-exchange enrollment made up the difference, and the actual combined decline was less than one percent.

That said, the State could take actions to grow—not just stabilize—New York’s individual market. There are more than a million New Yorkers remaining without health insurance. Table 2 indicates that health coverage is strongly associated with income, indicating that current prices are unaffordable to many New Yorkers.⁵ Particularly relevant to enrollment in the individual market is the steep affordability cliff when eligibility for the public Essential Plan ends and consumers must shop for a private Qualified Health Plan. HCFANY commends the New York State of Health for its efforts to keep plans affordable, including the lower deductible that will be available to people who enroll in Silver plans next year. Nevertheless, individuals making just \$25,000 a year (just over the Essential Plan cutoff) must pay around \$1,800 annually in premiums for a plan with a \$1,350 deductible. That’s over 12 percent of their gross income before they can use their coverage. This cost is unmanageable for many and simply not worth it for others.

Income as Percent of Federal Poverty Level (Individuals)	% of NY's Uninsured
<138% (\$17,235)	32%
138% -199% (\$17,236 - \$24,855)	16%

² New York State of Health, Open Enrollment reports for 2017, 2018, and 2019.

³ Rachel Schwab and Sabrina Corlette, “ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance, April 16, 2019, The Commonwealth Fund, <https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact>.

⁴ Data provided by the New York State Department of Financial Services.

⁵ American Community Survey, Health Insurance Status and Type of Coverage All People, 2008-2016.



200 - 399% (\$24,856 – \$49,835)	32%
400 - 599% (49,835 - \$74,815)	12%
Over 600% (Over \$74,816)	8%

HCFANY is also concerned about the number of New Yorkers who have insurance but say they still cannot afford care.⁶ Insurance degradation is real.⁷ In just a few years, premiums and deductibles have increased from 5.5 percent to 7.7 percent of an average New York family’s income. And nearly half of New Yorkers who have insurance are going without medications or treatment. If this continues, many New Yorkers may decide to stop buying health insurance altogether.

To address this coverage crisis, New York can follow the lead of California, New Jersey, and other states by taking two important steps beyond the rate review process.

First, New York should create an individual mandate. Any revenue generated by the state individual mandate must be used to either fund robust state premium assistance for people between 200 and 400 percent of the federal poverty level or to provide a down payment for expanding coverage to immigrants. The Urban Institute estimates that an individual mandate would reduce individual market premiums by 10 percent and raise \$271 million in New York.⁸

Second, the state should conduct targeted outreach to communities in which people are already eligible for cost-sharing reductions and premium assistance but are not enrolled. There are parts of the state with higher uninsured rates than others – additional outreach and enrollment funding should be targeted towards those communities. These two steps would result in an increase in the number of enrollees into the individual market and thus bring premiums down for both the existing and future enrollees there.

B. New York’s Individual Market Carriers Do Not Need Another Big Rate Increase

The Department can also nurture the individual market by rejecting increase requests that are not based on actual market conditions. In their applications for 2020, plans asked for the smallest average increase in several years: 8.4 percent. However, as described in Table 3, this comes after several years of double-digit requests that turned out to be much higher than necessary. The Department has lowered those requests every year, but even those lower increases appear to have been too generous. For example, the average rate increase request in 2018 was 16.6 percent. The Department had lowered the carriers’ average requests to 14.5

⁶ Altarum Healthcare Value Hub, “New Yorkers Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines,” Data Brief No. 37, March 2019, <https://www.healthcarevaluehub.org/advocate-resources/publications/new-yorkers-struggle-afford-high-healthcare-costs-support-range-government-solutions-across-party-lines/>

⁷ New York State Health Foundation, “The Rising Cost Burden of Employer-Sponsored Insurance in New York,” March 2018, <https://nyshealthfoundation.org/wp-content/uploads/2018/03/rising-cost-burden-employer-sponsored-insurance-NY.pdf>

⁸ Linda Blumberg, Matthew Buettgens, and John Holahan, “How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?,” July 20, 2018, <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/state-based-individual-mandate>



percent, but that still meant double-digit premium increases for thousands of New Yorkers (see Table 2).

The carriers’ argument that they need additional increases to respond to rising medical costs is belied by the fact that their average medical loss ratios for 2018 barely hover above the statutory minimum—and in several cases didn’t even make that. The medical loss ratio (MLR) shows what proportion of premiums carriers spend on medical care for their members. In 2018, the average MLR for New York’s individual carriers was only 83 percent, barely above the minimum 82 percent required by State law (see Table 3).

	Average Request	Average Approved	Number of Carriers	Average Medical Loss Ratio ⁹
2015¹⁰	12.5%	5.7% (-54%)	17	104.4%
2016¹¹	10.4%	7.1% (-32%)	17	102.0%
2017¹²	18.0%	16.6% (-8%)	17	95.6%
2018¹³	16.6%	14.5% (-13%)	15	83.0%
2019¹⁴	24.0%	8.6% (-72%)	14	N/A

Further, carriers in New York have continuously improved their performance in the individual market despite receiving significantly lower rate increases than they argued for. This suggests a habit of overstating their needs. Nationally, 2018 was the most profitable year yet for the individual markets created by the ACA.¹⁵ This looks to be true in New York as well. The requests for 2020 may be smaller than in prior years—but they are still likely too high considering this history of rate inflation and the increasingly strong financial performance of companies participating in New York’s individual market.

As described in detail below, the Department should reject premium increases where the carriers fail to control medical costs or their administrative expenses or simply fail to make the statutory minimal payments on medical claims. Moreover, the Department should not provide

⁹ MLRs are reported in Exhibit 13a, section D. The averages in Table 3 were calculated using the MLRs submitted in 2018 and 2019 for all carriers. Exhibit 13a provides MLRs for three years beginning with the first year in which data is complete, thus 2019 is not yet available.

¹⁰ Department of Financial Services, 2015 Individual Market Rate Action – Overall Summary, <https://myportal.dfs.ny.gov/web/prior-approval/summary-of-actions-premium-requests>.

¹¹ Department of Financial Services Press Release, July 31, 2015, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1507311.

¹² Department of Financial Services Press Release, August 5, 2016, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1608051.

¹³ Department of Financial Services Press Release, August 15, 2017, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1708151.

¹⁴ Department of Financial Services Press Release, August 3, 2018, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1808031.

¹⁵ Rebecca Pifer, “Payers had best individual market performance in 2018 since ACA began,” Healthcare Dive, May 8, 2019, <https://www.healthcaredive.com/news/payers-had-best-individual-market-performance-in-2018-since-aca-began/554366/>.



“repeater” adjustments annually for one-shot policy changes, such as the elimination of the individual mandate or the cost sharing reduction payments.

1. Medical trend estimates vary too much, and the State should require a standardized trend for either the entire state or the different rating regions

New York’s carriers need to do a better job controlling medical inflation. Their medical trend estimates in the 2020 rate applications range from 5.2 percent (Oscar) to 9.2 percent (United) with an average of 7 percent. Even when carriers work in the same region, they often estimate different trends. For example, Independent Health and Excellus both operate in Western New York, but estimate medical trends of 5.4 percent and 7.2 percent respectively. Further, for at least the third year in a row, the carriers argue that medical trend in New York will be higher than that expected by experts like Petersen-Kaiser (4.3 percent) or PwC (6 percent).¹⁶ Yet they provide no evidence about why this should be so year after year.

Medical Trend Estimates	
Petersen-Kaiser (2019)	4.3%
Milliman Medical Index¹⁷ (2018)	4.5%
PwC¹⁸ (2020)	6.0%
Segal Company¹⁹ (2019)	6.6%
CVS/Caremark (2019)	8.4%

Another concern is that carriers’ predictions of medical trend often exceed actual medical trend.²⁰ Over time, this means that they have accumulated excessive rates. Even an overestimate of 1 percent every year is integrated into the new base rate and adds up to big increases over time that were not needed to accommodate medical needs.

Consumers, and the State, depend on health insurers to negotiate with providers and pharmaceutical companies to keep prices down. In New York, too many insurers argue that they cannot do this. This indicates that the State should take a more aggressive role in controlling prices. The Department should consider stepping in by imposing a standard medical trend on the entire market of 4.3 percent per the Petersen-Kaiser estimate cited by HealthFirst. Insurers and providers would then negotiate prices with the understanding that overall medical trend must stay at that rate. If this is not possible, the Department could consider imposing regional benchmark medical trends and holding the carriers to them.

¹⁶ PwC, “Medical cost trend: Behind the numbers 2020,” June 2019, <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>.

¹⁷ Christopher Girod, Susan Hart, and Scott Wertz, “2018 Milliman Medical Index,” May 21, 2018, <http://www.milliman.com/mmi/>.

¹⁸ PwC, “Medical cost trend: Behind the numbers 2020,” <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>

¹⁹ Segal Consulting, “Increases in Medical and RX Costs Projected to Be Lower for 2019,” Fall 2018, <https://www.segalco.com/annual-health-plan-cost-trend-survey/2019/#PublicSector>.

²⁰ Segal Consulting, “Increases in Medical and RX Costs Projected to Be Lower for 2019,” Fall 2018, <https://www.segalco.com/annual-health-plan-cost-trend-survey/2019/#PublicSector>.



2. Carriers not meeting the state minimum MLR (or in danger of not meeting it) should not receive rate increases

Underscoring HCFANY's belief that the Department has been too generous with rate requests in the past is that the following four carriers failed to meet the State's minimum MLR of 82 percent in 2018: CDPHP, Excellus, Healthfirst, and Independent Health. A fifth, Fidelis, barely managed to meet the minimum at 82.4 percent. HCFANY has argued in past rate comments that the Department not allow the carriers to treat the minimum as a goal, but instead as an absolute floor to be avoided. Thus in our individual comments, HCFANY has asked that the Department reject an increase—and consider rate cuts—for each of these carriers.

HCFANY also asks that the Department look closely at the track record carriers have in estimating their MLR. For example, in its rate application for 2018 CDPHP said its goal was an MLR of 89.9 percent; its actual MLR (according to its 2020 application) was 81.3 percent. Similarly, Fidelis estimated its MLR would be 90 percent in 2018 when its actual MLR was 82.4 percent. HCFANY respectfully requests that the Department approve smaller increases than requested or even rate decreases for carriers that have a history of overestimating their MLRs.

3. Carriers that previously received upward adjustments for cost-sharing reductions and losing the individual mandate penalty should not receive duplicative adjustments this year

None of the carriers asking for rate increases due to the loss of the individual mandate penalty or the federal government's failure to pay for cost-sharing reductions explain why they should get a further adjustment for those factors. When those federal actions were taken, the Department stepped in to help the carriers respond. The adjustments the Department provided at that time are now incorporated into the carriers' base rate. If the carriers have data showing that previous rate adjustments were inadequate, they should provide that in their application. Otherwise, it appears that most of the carriers have already incorporated the conditions of no mandate and no cost-sharing reduction payments into their base rates. HCFANY respectfully urges the Department to reject duplicative rate adjustments.

4. The Department should look closely at administrative costs for New York's plans and not approve premium increases for the plans with the highest administrative costs

There is excessive variation in expense ratios within the 2020 applications, which range from 8 percent (MetroPlus) to 15.7 percent (Healthfirst). Health insurers should demonstrate that they can control administrative costs before requesting premium increases, especially those that have expense ratios that are higher than the other carriers like Healthfirst. Further, most of the carriers report that their expense ratios are increasing. Controlling and lowering administrative costs is key to being good shepherds of consumers' premium payments. HCFANY respectfully requests that the Department closely scrutinize carriers that are moving in the wrong direction and consider setting a state goal for administrative costs that is no higher than 10 percent.



II. Specific Issues in CDPHP's Application

CDPHP is a nonprofit that provides coverage to around 5,812 upstate New Yorkers. It increased its membership by 15 percent between 2017 and 2019 and reports plans to expand into new counties in 2019.

For 2020, CDPHP seeks a weighted average rate increase of 7 percent and a modest 1 percent profit. This rate increase is the highest request amongst the upstate carriers (Independent Health seeks 3.3%; Excellus seeks 4.2%, and MVP seeks 6.5%). Despite being awarded a 1.09 percent rate *decrease* last year, CDPHP still failed to make the statutory minimum medical loss ratio in New York State in 2018. Additionally, CDPHP appears to have a healthy enrollee population as a payer into the federal risk adjustment program. In its 2020 rate application, CDPHP seeks a substantial increase in administrative costs and expects a higher medical claims trend than last year.

A. CDPHP failed to meet the statutory minimum MLR in 2018

In its application, CDPHP indicates that it failed to meet New York State's statutory minimum medical loss ratio (MLR) of 82 percent in 2018. Its Actuarial Memorandum neither explains how it failed to make the minimum MLR nor does it offer any evidence for why it should make its projected MLR for 2020 of 86.4 percent. CDPHP's failure to make the minimum MLR is all the more vexing because the Department approved a rate *decrease* last year of 1 percent.

Already the most expensive PMPM of the upstate plans, there is little justification for a rate increase for CDPHP and the Department should again consider issue a rate decrease for this apparently over-priced plan.

Indeed, CDPHP's consumers are distraught at the idea that such an expensive plan could become even more pricy. As one consumer eloquently noted:

[CDPHP is] requesting an 8.6% increase, a percentage increase much greater than any annual salary increase I might receive. And, I think begs the question of how do you evaluate increase requests. If the cost of living % is in the low single digits—then how are consumer expected to fulfill an increase beyond what is expected in one's own salary increase—typically now around 2-3% per year? And if you look at their annual past increase for the last five years, one can see how significantly the premiums have risen. Two years ago I paid \$800/month, and now almost \$1,000/month. This is unreasonable and too significant of an increase for the customer to have to bear.

B. CDPHP did not provide enough information about the components of its trend estimate



Historically, CDPHP had amongst one of the lowest medical trends in New York of roughly 5.5, which indicated it was relatively effective at controlling costs. However, this year, it seeks a medical trend of 6.7 percent, without any meaningful justification. As describe in the general comments of this letter, medical trend nationally is stabilizing. CDPHP’s actuarial memorandum offers no explanation for its medical trend estimates for the second year in a row. In fact, the discussion it does offer indicates that it anticipates more services will be provided in an outpatient setting, which presumably is a justification for a medical trend that would be *decreasing*, not increasing.

HCFANY urges the Department to deny any adjustment for medical trend for CDPHP given its failure to offer any evidence for its projections.

C. CDPHP provides no justification for its surging expense ratio

CDPHP historically has had a 9 percent expense ratio. This year, in its application, CDPHP projects a 12.6 percent expense ratio. There is no explanation provided for this jump. The sum total of CDPHP’s explanation for its expense ratio is this: “The administrative expense load is based on actual 2018 administrative expense, along with 2019 budgeted expense in the current individual market.”

HCFANY objects to this statement on two grounds. First, it is simply inadequate. No explanation of what constitutes its expense ratio or why it is increasing by nearly 3 percent is offered. Second, it appears to be wrong. According to its filings, in 2018, CDPHP’s expense ratio appears to have been 9.18 percent. In 2019, it appears to have increased to 9.5 percent. That does not add up to be the 12.6 percent CDPHP now projects for 2020.

D. CDPHP’s request for another cost-sharing reduction may be duplicative

In 2017, the Department incorporated a rate adjustment to account for the loss of cost-sharing reductions in CDPHP’s approved 2018 rates. CDPHP seeks a further adjustment for the loss of CSR payments in its 2020 rates. There is no explanation for why the previous increase was insufficient. Moreover, because New York elected to offer the Basic Health Plan option, there are very few people receiving CSRs and those that do are simply receiving a slightly smaller deductible. CDPHP’s request is small, but small unnecessary increases in premiums compound over time.

The Department should disallow duplicate year-after-year adjustments for the loss of CSRs for all carriers. An appropriate adjustment for this condition is already part of the carriers’ base rates. In addition, three plans (Independent Health, Healthfirst, and Health Plus) do not seek any adjustment for the CSR change that occurred in 2018.

Accordingly, HCFANY urges the Department to reject CDPHP’s request for an increase and consider again reducing its rates, given its historical inability to meet the statutory minimum MLR and its effort to seek a rate increase with little to no concrete support offered for it in its Actuarial Memorandum.



Thank you for your attention.

Very truly yours,

A handwritten signature in blue ink, which appears to read "Amanda Dunker". The signature is written in a cursive style with a large initial "A" and a distinct "D".

Amanda Dunker
Senior Health Policy Associate
Community Service Society of New York