Actors Fund ○ African Services Committee ○ 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 ○ Young Invincibles

June 29, 2020

Linda A. Lacewell, Superintendent
John Powell, Assistant Deputy Superintendent for Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: Requested Rate Changes – HealthFirst – HLFT-131929375

Dear Superintendent Lacewell 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 2.4 percent increase requested by HealthFirst.

I. Market-Wide Conditions

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, thanks to strong leadership at the state and local levels.[1] Complementing the state's strong commitment to public programs, New York's individual insurance market is an important component of this coverage success, having increased coverage from roughly 19,000 in 2013 to over 273,000 today.[2] Most people in New York's individual health insurance market receive federal premium subsidies. However, 42 percent of such enrollees sign up for health insurance even without financial assistance. The New

[1] NY State of Health, "Press Release: NY State of Health Announces Record High Enrollment More than 4.9 Million New Yorkers Enrolled," February 20, 2020, https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-record-high-enrollment-more-49-million-new-yorkers.
[2] Id. Key to New York's coverage success is its implementation of a state-of-the-art eligibility rule engine in the Marketplace, it's robust enrollment assistance programs, and its adoption of the Basic Health Plan, under Section 1331 of the ACA.

York State of Health Marketplace (NYSOH) continues to attract new members – 23 percent of enrollees during the 2020 open enrollment were new enrollees rather than renewals. Moreover, after the COVID-19 pandemic began, New York's individual market provided a haven for newly uninsured New Yorkers facing unexpected health and economic risks by establishing a special enrollment period from March through July 2020.

But despite this progress, over 1 million New Yorkers remain uninsured; further, many of those who are insured say coverage is unaffordable.[3] These concerns are all the more troubling because both issues fall disproportionately on immigrants and communities of color who are more likely to be uninsured, due to systemic health policy choices at the federal, state, and local levels. In addition, nearly half of New Yorkers who have insurance are going without medications or treatment because of increasingly high cost-sharing.[4]

New York should follow the lead of California, Illinois, New Jersey, Maryland, and other states by taking four important steps outside of rate review to reduce the number of uninsured and approve affordability for others.

First, New York should provide coverage to its immigrant residents who have been historically left behind by exclusionary coverage policies at the state and national levels. Many immigrants live in communities that suffered the most morbidity and mortality during the on-going COVID-19 pandemic. To redress these discriminatory policies, New York should establish a state-only funded Essential Plan for low-income immigrants whose status bars them from enrolling in coverage.[5] Last year, California led the way by providing coverage to its uninsured undocumented immigrant young adults, and Illinois has likewise offered coverage to its uninsured undocumented immigrant seniors.[6]

Second, to help address New York's insurance affordability crisis, like Massachusetts, Vermont and others, New York should establish a robust state premium assistance program for people between 200 and 400 percent of the federal poverty level paired with the adoption of a state individual mandate (which in itself would drive down insurance costs). The Urban Institute

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[3] 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/

[4] "The Rising Cost Burden of Employer-Sponsored Insurance in New York," New York State Health Foundation, March 2018, https://nyshealthfoundation.org/wp-content/uploads/2018/03/rising-cost-burden-employer-sponsored-insurance-NY.pdf; Nationally, deductibles grew 55 percent nationally between 2010 and 2016: Leonard Davis Institute of Health Economics, "The Burden of Health Care Costs for Working Families: A State-Level Analysis," April 2019, available at https://ldi.upenn.edu/brief/burden-health-care-costs-working-families.

[5] Elisabeth Benjamin, "How New York Can Provide Health insurance Coverage to its Uninsured Immigrant Residents," January 2016, https://www.cssny.org/publications/entry/covering-new-yorks-uninsured-immigrant-residents

[6] Sammy Caiola, "Young Undocumented Immigrants Cheer Promise of Health Benefits," July 11, 2009, https://www.npr.org/sections/health-shots/2019/07/11/739536305/young-undocumented-californians-cheer-promise-of-health-benefits; Kade Heather, "Illinois to become 1st state to provide Medicaid regardless of immigration status," The State Journal-Register, May 27, 2020, https://www.sj-r.com/news/20200527/illinois-to-become-1st-state-to-provide-medicaid-regardless-of-immigration-status

estimates that an individual mandate would reduce premiums by 10 percent and raise $271 million in New York.[7]

Third, the state should direct enhanced outreach and enrollment assistance in communities where people are already eligible for premium assistance or public coverage but are not enrolled. These first three 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.

Fourth, New York State must take back its rate-setting role to restore reasonable health care costs. Hospital inpatient prices are the biggest component of increases in insurance spending in New York.[8] Until 1997, the New York Prospective Hospital Reimbursement Methodology was used to control price increases and distribute health care resources based on population need. At the time, hospital rate deregulation was adopted under the premise that the market forces (i.e. insurance and other payers) would be able to better control costs. But these free market policies have failed. Providers with the most market power set the highest prices and use their revenue to further consolidate New York's healthcare market, which diverts resources away from underserved communities of color and drives up prices for us all. In short, without government intervention, our health care markets are broken with the inexorable result that consumer premiums go up at rates faster than in other states – and health care is divested from all but the wealthiest areas.[9] Ultimately, to control costs and ensure health equity, the State should adopt the New York Health Act because it would both control provider prices and eliminate most non-health care administrative costs associated with private insurance.[10]

Leveraging the State's Regulatory Muscle on Behalf of New York's Health Insurance Consumers through Prior Approval for 2021 Insurance Rates

For 2021, New York should aggressively leverage the prior approval process to protect consumers from large premium increases. This year, often using the pretext of the COVID-19 pandemic, New York's insurance carriers are asking for an average increase of 11.2 percent—despite a historic decrease in 2020 utilization related to the pandemic. These arguments should be rejected. New York's carriers have a history of asking for large rate requests that prove unnecessary. For years, New York's individual market plans issued urgent appeals to the state for help "stabilizing" the individual market through increased premiums to counter a "death spiral" that never materialized. Instead, these incorrect projections have led to large rate increases that resulted in many plans' failure to make even the minimum medical loss ratios in

[7] 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
[8] NYS Health Foundation and Health Care Cost Institute, "Health Care Spending, Prices, and Utilization for Employer-Sponsored Insurance in New York," July 2019, https://nyshealthfoundation.org/wp-content/uploads/2020/02/Health-Care-Spending-in-NY-2019.pdf.
[9] Amanda Dunker and Elisabeth Benjamin, "How Structural Inequalities in New York's Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform, June 2020, https://www.cssny.org/news/entry/structural-inequalities-in-new-yorks-health-care-system.
[10] Liu et al., "An Assessment of the New York Health Act: A Single-Payer Option for New York State," RAND Corporation, 2018, https://www.rand.org/pubs/research_reports/RR2424.html.

the subsequent years. HCFANY respectfully asks that the Department of Financial Services ("the Department") treat current claims about the impact of COVID-19 with skepticism considering this history of false alarms.

In addition, HCFANY asks that the Department reduce premium requests or impose decreases on behalf of New York's consumers for the following reasons:

- The carriers' estimated medical loss ratios are too close to the legally required 82 percent—especially since several plans have not met the legal requirement over the past three years—indicating a lack of regulatory rigor in past annual rate reviews.
- The carriers' failure to control medical trend as rigorously as their counterparts in other states—New York's regulators should reject vague and inconsistent trend projections.
- The carriers seek duplicative rate increases for changes that already were built into prior years' base adjustments, such as the loss of the individual mandate and the loss of federal cost-sharing reduction payments.
- The carriers seek to spend too much of the premiums they collect on administrative costs and several plans reported increases in administrative costs.

The stability and success of New York's individual market has been in large part due to the Department's strong leadership and responsiveness to the needs of consumers. HCFANY urges the Department to continue championing New York's consumers through a careful analysis and reduction of the carriers' 2021 rate requests as well as the establishment of transparent state benchmarks (or collars) for key components of the rates, such as medical trend, profits, and administrative loads.

A. It is premature to grant rate adjustments for COVID-19

Most of the carriers seek increases attributable to the COVID-19 pandemic, ranging from 1 percent (Excellus) to 11.5 percent (Fidelis). These requests contradict insurer projections in the trade press. In a survey of 33 major health insurance companies, most said they did not anticipate needing premium increases due to COVID-19.[11] Despite this, only three out of ten of New York's plans did not request an increase due to COVID-19: the Capital District Physicians Health Plan, Healthfirst, and the Independent Health Benefits Corporation.

In fact, the pandemic has resulted in drastically fewer claims because most non-COVID-19 related care has stopped for several months. Even when care is available, 30 percent of Americans have reported delaying medical care to reduce exposure to the virus.[12] Yet not one plan has offered to rebate or reinvest these savings in the reduction of New York's consumers' health insurance premiums for 2020 or 2021. In short, the carriers have simply secured an

[11] eHealth, "Health Insurers Respond to COVID-19: A Survey, "April 2020, https://news.ehealthinsurance.com/_ir/68/20203/Health_Insurers_Respond_to_Covid-19_An_eHealth_Survey.pdf.
[12] Morning Consult and the American College of Emergency Physicians, "COVID-19," April 2020, https://www.emergencyphysicians.org/globalassets/emphysicians/all-pdfs/acep-mc-covid19-april-poll-analysis.pdf

interest-free loan from New York's insurance consumers through the payment of premiums for an unusually low-utilization year.

Insurers seeking a COVID-19 rate increase offer many unsupported rationales that the Department should reject. Some argue that depressed utilization will result in a surge of "pent up demand" in utilization during 2021 without acknowledging that the carriers already have been paid for this offset utilization through their current (2020) premiums. In addition, no carrier has sought an adjustment for the reality that many consumers will likely forgo some care *entirely* because they were unable to access it during the pandemic and the economic downturn. Research conducted during the last recession shows that when the economy contracts, consumers use fewer health care services.[13] Some analysts have suggested that insurance companies will actually benefit from the pandemic – even with infection rates 14 times higher than the current 1 percent.[14] Similarly, COVID-19 sparked an increase in telehealth utilization that will likely translate to long-term savings for health plans. Telehealth is a less expensive means of providing care, and industry experts believe the shift to virtual care represents a cultural change in healthcare that will long outlast COVID-19.[24] New York's plans will reap savings from the transition to telehealth for years to come, likely offsetting any detrimental COVID-19 impact to their balance sheets.

Other plans ask for rate increases to cover the costs of administering a theoretical COVID-19 vaccination. But no such vaccine exists. Moreover, even if a vaccine is developed, approved by the Food and Drug Administration, and successfully manufactured on a mass scale, it is unlikely to be widely available in 2021 even under the most optimistic scenario.[15] And when a vaccine in developed, priority will likely go to those at the most risk – most of whom are covered by Medicare and not in the individual market.

In addition, it is unclear if the plans would even bear the costs of the COVID-19 vaccine. HHS Deputy Secretary Brett Giroir said he is committed to distributing the vaccine to "all segments of society regardless of their ability to pay or any other social determinants of health there may be."[26] Similar statements date back at least to the March 6 coronavirus funding package, which stipulated that any COVID-19 vaccine should be priced "fairly and reasonably."[27] Both the House and Senate are currently entertaining bills that would limit drug companies' pricing of such a vaccine,[28] and some drug companies, such as Gilead Sciences Inc. and Merck & Co., preempted the pricing discussion by vowing to ensure affordability or even to supply the vaccine at no cost in some situations.[29] Significant discussion among politicians, administrative bodies, and industry players indicates a high probability of government or industry assistance to reduce the cost to insurers of administering the vaccine.

[13] Jill Bernstein, "Impact of the Economy on Health Care," Changes in Health Care Financing & Organization Initiative, August 2009, hcfo.org/files/hcfo/findings0809_0.pdf.

[14] Isaac Arnsdrof, "Health Insurers to Investors: We're Good. Health Insurers to Lawmakers: Please Help," ProPublica, April 28, 2020, https://www.propublica.org/article/health-insurers-to-investors-were-good-health-insurers-to-lawmakers-please-help.

[15] Caroline Chen, "How – and When – Can the Coronavirus Become a Reality?," ProPublica, June 17, 2020, https://www.propublica.org/article/how-and-when-can-the-coronavirus-vaccine-become-a-reality

Likewise, the Department should not allow plans to increase rates for the speculative utilization of hypothetical treatments. As HealthPlus states in its Actuarial Memo, incorporating COVID-19 increases into 2021 rates would be "speculative" and "outside the bounds of standard actuarial practice." As will be discussed below, New York's individual plans have performed well for several years now and had ample time to build up reserves for unanticipated events like COVID-19. Those that have not done so before are now in a good position to build up their reserves as claims dwindle.

HCFANY asks that the Department reject all requested increases related to the pandemic. And any COVID-19 adjustments should be made with real—not conjectural —utilization data and implemented in 2022.

B. Medical loss ratios

Many of the carriers' medical loss ratios (MLRs) indicate that individual market premiums in New York have been overpriced for several years running. The MLR shows what proportion of premiums carriers spend on medical care for their members. New York State law requires MLRs of at least 82 percent.

The most recent exhibits show that the average MLR in New York's individual market decreased from 92.3 percent in 2017 to 87.5 percent in 2019 (see Table 1). In 2018, the average MLR was only 85.4 percent. This decrease followed three years of large rate increases: 16.6 percent in 2017 and 14.5 percent in 2018. In 2017, three carriers reported MLRs of over 100 percent, indicating losses. But no individual market carrier reported a loss in 2018 or in 2019.

Table 1. Individual Market Rate Changes and Medical Loss Ratios, 2017-2019

	Average Request	Average Approved	Average Medical Loss Ratio[16]	Number of Carriers At or Below 82% MLR
2017[17]	18.0%	16.6% (-8%)	92.3%	2
2018[18]	16.6%	14.5% (-13%)	85.4%	4
2019[19]	24.0%	8.6% (-72%)	87.5%	3

In fact, in 2018 and 2019, several carriers failed to meet the legal requirement of 82 percent. This occurred three times in 2018: CDPHP, Excellus, and Independent Health all had MLRs below 80 percent, and a fourth carrier, Fidelis, barely managed to meet the minimum at 82.4 percent. In 2019, three plans failed to meet the required MLR (Fidelis, Healthfirst, and

[16] MLRs are reported in Exhibit 13a, section D. The averages in Table 3 were calculated using the MLRs submitted in 2018, 2019, and 2020 for all on-exchange carriers. Exhibit 13a provides MLRs for three years beginning with the first year in which data is complete.
[17] Department of Financial Services Press Release, August 5, 2016, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1608051.
[18] Department of Financial Services Press Release, August 15, 2017, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1708151
[19] Department of Financial Services Press Release, August 3, 2018, https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1808031.

Independent Health). HCFANY has argued in past rate comments that the Department does not allow the carriers to treat the minimum as a goal, but 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.

The carriers are likely to argue that failure to make an MLR is offset by later individual consumer rebates. There are two concerns with this argument. First, it forces cash-strapped consumers in the middle of a recession to shoulder the burden of the carriers' failed rate projections. When consumers see their premiums go up year after year just to hear about insurers record profits, it reduces their faith in the State to fairly regulate insurance costs. Second, many consumers are difficult to track down 18 months after the fact, leaving these rebate windfalls to be pocketed by the carriers.

In any event, the Department should adopt a transparent reporting and accounting process for any rebates, so New York's consumers' rebates of premiums overpayments are fully accounted for and publicly disclosed.

HCFANY also asks that the Department look closely at the track record carriers have in estimating their MLR, especially for those that are predicting an MLR close to the minimum. This year, five plans are predicting an MLR of 85 percent or lower. This includes Independent Health, which has had an MLR of about 72 percent two years in a row. HCFANY respectfully requests that the Department approve substantially smaller increases than requested or in a number of cases, rate decreases, for carriers that are predicting MLRs with so little buffer.

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

Medical trend estimates in the 2020 rate applications range from 4.8 percent (Oscar) to 9.2 percent (United) with an average of 7 percent. Further, for at least the fourth year in a row, the carriers argue that medical trend in New York will be higher than that expected by experts:

- Health plans reported an average of 7 percent expected trend for 2020 to Segal Consulting – however, Segal Consulting found that these predictions were higher than actual results every year since 2009.[20] In 2017 plans predicted a medical trend of 7.6 percent, but actual costs only increased by 5.7 percent. In 2018 the prediction was 7.7 percent, but the actual trend was 6.3 percent.
- PriceWaterhouseCooper found that medical cost trend was 5.7 percent in both 2018 and 2019 and estimated 6 percent for 2020.[21]

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[20] Segal Consulting, "Medical and Rx Cost Increases Are Leveling Off," Fall 2019, https://www.segalco.com/media/1664/segal_trend_survey_2020.pdf.
[21] PWC Health Research Institute, Medical cost trend: Behind the numbers 2020, June 2019, https://www.pwc.com/us/en/industries/health-industries/assets/pwc-hri-behind-the-numbers-2020.pdf.

- Deloitte predicted global health spending increased 3.2 percent in 2019 and predicts an overall increase of only 5 percent between 2019 and 2023.[22]
- The Milliman Medical Index has found that medical costs grew by just: 2.9 percent from 2017 to 2018; 3.8 percent from 2018 to 2019;[23] and 3.2 percent from 2019 to 2020.[24]

Additionally, major private market carriers have predicted a medical trend of only 4.8 percent for 2021.[25] There is no explanation in the rate applications for why New York's medical inflation rate should be higher than that in every other insurance market in the nation—begging the question of the value of insurance when they are unable to effect healthcare bargains for their enrollees. To the extent that the problem is the carriers' unwillingness or inability to negotiate reasonable reimbursement rates with providers on behalf of their enrollees, then it is high time for the state to step in this negotiating void and reestablish a global hospital rate setting program that New York consumers' healthcare costs are effectively controlled.

In addition, the carriers' predictions of medical trend often exceed actual medical trend.[26] Actual trend has turned out to be much lower than national estimates in recent years – national estimates that New York's carriers consistently surpass.[27] Prices for medical services and goods only increased 1.2 percent between 2014 and 2018 nationally, far lower than the price increases reported by New York's carriers (though many carriers fail to provide even this much information about the components of their trend estimate).[28] Over time, this means that New York's carriers 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, 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 (or even a collar) for the state's community rated individual and small group markets. Insurers and providers would then negotiate prices with the understanding that overall medical trend must stay at that rate.

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[22] Stephanie Allen, "2020 global health care outlook," Deloitte Insights, 2019, https://www2.deloitte.com/content/dam/insights/us/articles/GLOB22843-Global-HC-Outlook/DI-Global-HC-Outlook-Report.pdf.
[23] Girod et al., "2019 Milliman Medical Index," July 2019, https://www.milliman.com/en/insight/-/media/Milliman/importedfiles/ektron/2019-milliman-medical-index.ashx.
[24] Girod et al, "2020 Milliman Medical Index," May 2020, https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/2020-milliman-medical-index.ashx.
[25] Health Affairs, "Primary Drivers of Projected Increased Growth Are Anticipated Increases in Inflation for Medical Goods and Services," March 24, 2020, DOI: 10.1377/HBLOG20200323.215410.
[26] 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.
[27] Segal Consulting, "Medical and Rx Cost Increases Are Leveling Off," Fall 2019, https://www.segalco.com/media/1664/segal_trend_survey_2020.pdf.
[28] Health Affairs, "Primary Drivers of Projected Increased Growth Are Anticipated Increases in Inflation for Medical Goods and Services," March 24, 2020, DOI: 10.1377/HBLOG20200323.215410.

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

The carriers that seek rate increases due to the loss of the individual mandate penalty or the federal government's failure to pay for cost-sharing reductions fail to explain why they should get a further adjustment for those factors for a third year in a row. If they 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 for these reasons.

E. 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

The Department should address the wide variation in expense ratios among the 2020 applications, which range from 8 percent (MetroPlus) to 15.7 percent (Healthfirst). The Department should disallow out-of-control administrative costs for carriers like Healthfirst and closely scrutinize large, unexplained increases in administrative costs for others.

Controlling the carriers' administrative costs is key to being good shepherds of consumers' premium payments. HCFANY respectfully requests that the Department closely scrutinize any adjustments that are increasing from the prior year and consider setting a state goal for administrative costs that is no higher than 10 percent. The Department has limited administrative costs in the past by rejecting profit ratios over 1.5 percent. HCFANY asks that the Department continue this practice and consider limiting profit ratios to 1 percent this year, in light of the projected economic downturn.

II. Specific Issues in HealthFirst's Application

HealthFirst is a provider-sponsored non-profit carrier that sells individual market coverage in New York City and Long Island. Its proposed rate increases are for plans sold in New York City only. Its individual market plans have about 39,980 members in 2020, a nearly 9 percent increase from 2019. The carrier has increased membership by 29 percent since 2017, one of several plans to expand its pool despite the absence of an individual mandate. HealthFirst anticipates that its members will have a better morbidity than the rest of New York and expects to pay about 1 percent of its revenue into the federal risk adjustment program.

HealthFirst is asking for an average 2.4 percent rate increase for 2021, which is lower than the 11.8 percent average request in New York's individual market. However, HCFANY has identified several issues with HealthFirst's application and urges the Department instead to authroize a rate decrease for the carrier's NYC plans.

Of particular concern is that HealthFirst missed the MLR minimum mark by a wide margin in the past year. HCFANY is also concerned that the carrier is asking for increases based on very high administrative costs, as well as for a new diabetes benefit that no other carrier has identified as a potential contributed to higher costs.

HCFANY also notes that complaint data from HealthFirst is not included in the Department's annual Consumer Guide to Health Insurers. HCFANY believes this makes it difficult for consumers to compare HealthFirst to other carriers. A lack of publicly available consumer complaint data also inhibits the ability of the Department, consumers and advocates to clearly gauge HealthFirst's performance, relative to its competitors.

A. HealthFirst failed to meet the required MLR in 2019 by a large amount and was too near the limit in 2018.

HealthFirst had very low MLR of 74.3 percent in 2019, far below the 82 percent requirement. This was a drop-off from 2018 when the carrier's MLR of 83.1 barely exceeded the minimum. HealthFirst projects that its 2021 MLR will likewise just meet the required threshold. This is of particular concern given the downward trend over the past several years. The plan does not present any concrete steps to explain how it plans to improve its propensity to for failing to meet the minimum statutory MLR performance.

Over the past two years, the Department has enabled HealthFirst's low MLR by granting it multi-year increases of 9.5 percent and 16.6 percent in 2019 and 2018, respectively. In retrospect, both of these approvals were unwarranted. The plan also appears to have a large and healthy risk pool, as evidenced by their anticipated payment into the federal risk pool. Given these facts, HCFANY strongly encourages the Department address the needs of New Yorkers in the current economic downturn and authorize a substantial rate reduction on behalf of HealthFirst's members.

B. HealthFirst has the highest expense ratio of any carrier.

HealthFirst is a Prepaid Health Services Plan, owned and operated by a consortium of hospitals. The carrier has existed for more than 25 years, first as a Medicaid Managed Care plan and now as a multi-product carrier with offerings across the individual and small business marketplace. Despite this long history, the plan requests that the Department approve administrative costs that would be the highest in New York's individual market at 15 percent. Across New York's individual market, the average projected cost for 2021 is just 11.9 percent. HealthFirst should be leveraging its close connections with providers (as a provider sponsored plan), its long experience in the Market to build economies of scale to keep administrative costs well below the market average. In no event, as the fiscal steward for New York's individual market consumers, should the Department authorize such an enormous administrative ratio.

C. HealthFirst is a not-for-profit carrier but is asking for a profit margin on par with for-profits.

HealthFirst is requesting a 1.5 percent surplus. This is significantly higher than other non-profit carriers like MetroPlus and Capital District Physician's Health Plan, who have both asked for a 1 percent pre-tax profit ratio. HCFANY believes HealthFirst should be kept to the same profit standard as other non-profit carriers.

D. HealthFirst does not fully explain important factors that they say will increase costs.

Healthfirst anticipates that a new benefit to cover diabetic benefit will take an additional 0.27 percent from claim income. This new benefit is not priced or claimed by other carriers. The Department should consider this impact to be included with pharmacy trend, or should account for a standard increase across plans rather than allowing HealthFirst to unilaterally make this adjustment, that has an adverse impact on its members. Elsewhere in their application, HealthFirst indicates that they submitted an Out-of-Network rider, which by itself will add 0.33 percent to premiums. Without explaining this rider or how it would drive costs, they estimate an additional 0.33 percent increase if approved.

As with the highest-in-class administrative costs claimed by HealthFirst, these two areas underscore HealthFirst's history of a lack of transparency and commitment to keeping costs low for consumers in its rate filings and both should be disallowed without a robust public explanation.

E. HealthFirst projects a high medical trend despite citing lower trends.

HealthFirst sees claim trend climbing 6.7 percent in the coming year, which is about on par with the average projection of 6.93 percent. However, in their Actuarial Memo HealthFirst cites multiple estimates that are in fact lower for the coming year, including Deloitte (which puts overall trend at 5.4 percent between 2018 and 2022) and PWC Medical Cost Growth (6.0 percent for 2020). HealthFirst's trend factor should be held to the standards on which their own memo relies.

F. HealthFirst is creating income from premiums collected through investment.

HealthFirst reaped a 2.32 percent return on surplus premiums invested in 2019. This additional income is very much at odds with the carrier's not-for-profit status. HealthFirst says that a surplus is needed to invest in company infrastructure, yet there is no evidence of this investment in their high administrative costs.

HCFANY respectfully requests that the Department closely examine HealthFirst's record in returning premium dollars to care for enrolled New Yorkers in the past years, with particular attention paid to the carrier's very low MLR and high administrative expenses. HCFANY believes HealthFirst's rates should be reduced, not increased, in the coming year.

Thank you for your attention.

Very truly yours,

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