



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 24, 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 – Oscar – OHIN 132374995**

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 19.1 percent increase requested by Oscar.

**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.<sup>1</sup> 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.<sup>2</sup> 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

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<sup>1</sup> 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>.

<sup>2</sup> Id. Key to New York's coverage success is its implementation of a state-of-the-art eligibility rule engine in the Marketplace, its 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.<sup>3</sup> 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.<sup>4</sup>

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 ongoing 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.<sup>5</sup> 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.<sup>6</sup>

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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<sup>3</sup> 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/>

<sup>4</sup> “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>.

<sup>5</sup> 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>

<sup>6</sup> 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 1<sup>st</sup> 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-medicare-regardless-of-immigration-status>



estimates that an individual mandate would reduce premiums by 10 percent and raise \$271 million in New York.<sup>7</sup>

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.<sup>8</sup> 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.<sup>9</sup> 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.<sup>10</sup>

### **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

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<sup>7</sup> 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>

<sup>8</sup> 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>.

<sup>9</sup> 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>.

<sup>10</sup> 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](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.<sup>11</sup> 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.<sup>12</sup> 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

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<sup>11</sup> 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](https://news.ehealthinsurance.com/ir/68/20203/Health_Insurers_Respond_to_Covid-19_An_eHealth_Survey.pdf).

<sup>12</sup> 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.<sup>13</sup> 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.<sup>14</sup> 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.<sup>24</sup> 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.<sup>15</sup> And when a vaccine is 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.”<sup>26</sup> 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.”<sup>27</sup> Both the House and Senate are currently entertaining bills that would limit drug companies’ pricing of such a vaccine,<sup>28</sup> 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.<sup>29</sup> 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.

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<sup>13</sup> 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](https://www.hcfo.org/files/hcfo/findings0809_0.pdf).

<sup>14</sup> Isaac Arnsdof, “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>.

<sup>15</sup> 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 <sup>16</sup>	Number of Carriers At or Below 82% MLR
<b>2017<sup>17</sup></b>	18.0%	16.6% (-8%)	92.3%	2
<b>2018<sup>18</sup></b>	16.6%	14.5% (-13%)	85.4%	4
<b>2019<sup>19</sup></b>	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

<sup>16</sup> 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.

<sup>17</sup> Department of Financial Services Press Release, August 5, 2016, [https://www.dfs.ny.gov/reports\\_and\\_publications/press\\_releases/pr1608051](https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1608051).

<sup>18</sup> Department of Financial Services Press Release, August 15, 2017, [https://www.dfs.ny.gov/reports\\_and\\_publications/press\\_releases/pr1708151](https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1708151)

<sup>19</sup> Department of Financial Services Press Release, August 3, 2018, [https://www.dfs.ny.gov/reports\\_and\\_publications/press\\_releases/pr1808031](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.<sup>20</sup> 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.<sup>21</sup>

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<sup>20</sup> Segal Consulting, “Medical and Rx Cost Increases Are Leveling Off,” Fall 2019, [https://www.segalco.com/media/1664/segal\\_trend\\_survey\\_2020.pdf](https://www.segalco.com/media/1664/segal_trend_survey_2020.pdf).

<sup>21</sup> 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.<sup>22</sup>
- 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;<sup>23</sup> and 3.2 percent from 2019 to 2020.<sup>24</sup>

Additionally, major private market carriers have predicted a medical trend of only 4.8 percent for 2021.<sup>25</sup> 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.<sup>26</sup> Actual trend has turned out to be much lower than national estimates in recent years – national estimates that New York’s carriers consistently surpass.<sup>27</sup> 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).<sup>28</sup> 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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<sup>22</sup> 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>.

<sup>23</sup> Girod et al., “2019 Milliman Medical Index,” July 2019, <https://www.milliman.com/en/insight/-/media/Milliman/importedfiles/ektron/2019-milliman-medical-index.ashx>.

<sup>24</sup> Girod et al., “2020 Milliman Medical Index,” May 2020, <https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/2020-milliman-medical-index.ashx>.

<sup>25</sup> 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](https://doi.org/10.1377/HBLOG20200323.215410).

<sup>26</sup> 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>.

<sup>27</sup> Segal Consulting, “Medical and Rx Cost Increases Are Leveling Off,” Fall 2019, [https://www.segalco.com/media/1664/segal\\_trend\\_survey\\_2020.pdf](https://www.segalco.com/media/1664/segal_trend_survey_2020.pdf).

<sup>28</sup> 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](https://doi.org/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 Oscar's Application**

Oscar is among the largest carriers in New York's individual market, with over 33,500 members in 2020. Because of its relatively healthy membership, it anticipates being the biggest payer into the risk adjustment pool for 2021.

Oscar's rate application does not provide enough detail to justify its rate increase for 2021. HCFANY asks that the Department carefully evaluate Oscar's 2021 rate application, especially because of its large request, its high profit expectations, the size of its provider networks, and because its COVID-19 adjustment does not stand up to scrutiny.

**A. Oscar's request for a 19.1 percent increase dwarfs other carriers' requests without clear justification**



Oscar's request for a 19.1 percent increase dwarfs the average 2021 rate increase of 11.8 percent without adequate justification. The rate increase is particularly inexplicable because Oscar predicts the lowest annual claim trend of all the carriers (4.8 percent) and lower administrative costs than average for 2021 (10.7 percent).

Oscar is a relatively new plan with a history of very large premium hikes, including a 14 percent increase for 2020 and an 11 percent increase for years 2018-2019. These compounding increases are difficult for members to manage, and it is unsurprising that Oscar witnessed a substantial 19 percent decline in enrollment last year.

Some observers might argue that Oscar's relatively recent entrance into the New York market is a rational explanation for its history of large rate increases. However, six years in, Oscar is now an established carrier in New York, and beyond—it expanded to six states in 2020 alone. Oscar's MLRs have shrunk substantially. In 2016 it posted a medical loss ratio of 124 percent, which indicated the need for a rate increase. But since that time, Oscar has always had an MLR under 100 percent. Oscar's MLR goal for 2021 is only 87 percent. Yet Oscar still seeks a double-digit rate increase. Another big rate increase could drive more of Oscar's customers away and is not necessary to keep the plan stable. HCFANY asks that the Department greatly reduce Oscar's request.

**B. Oscar is seeking the highest pre-tax profit ratio (2.4 percent) of any QHP while requesting the largest increase in the market**

Most carriers are requesting a profit ratio of 1.5 percent, which is what the Department has prudently approved in past years. HCFANY asks that the Department continue this practice or even consider limiting profit ratios for 2021 to 1 percent, given the likelihood that a recession will make it difficult for many consumers to manage rate increases.

**C. Oscar has never made an appropriate downward adjustment in rates to reflect its much-diminished provider networks**

Oscar continues to offer a smaller-than-average network to its members. Three years ago, Oscar made drastic reductions to its New York networks: To control costs, Oscar cut half of its physicians (20,000 of them) and 60 percent of its hospitals (down to just 31). Oscar's members then experienced two years of rate hikes despite participating in a vastly different, and reduced, product. Oscar's network is still incredibly small for the size of its membership. According to the 2019 New York Consumer Guide to Health Insurers, Oscar had only 25 board-certified obstetrician-gynecologists and 11 board certified pediatricians in its network. The availability of these commonly utilized providers is astonishingly low, especially considering that Oscars' competitors have, on average, at least 70 board-certified OB-GYNs and pediatricians in their networks.

**D. Oscar's assessment of COVID-19's impact on its expenses does not stand up to scrutiny**



The Department should closely examine Oscar’s justifications for its COVID-19 impact assessment, which at a staggering 7.4 percent more than double the average impact rate of 3.1 percent. This is at odds with several other carriers, such as Metroplus, Independent Health Benefits Corporation, Healthplus, and others which have not requested a rate adjustment for hypothetical treatment and vaccine offerings in 2021.

In particular, Oscar justifies its COVID-19 rate increase by relying on an outdated JP Morgan study to argue that there will be pent-up demand for healthcare services in 2021. This rationale fails to consider that carriers have already been paid for this offset utilization through current (2020) premiums, and that many members may decide to forego certain care entirely until a coronavirus vaccine is developed.

Likewise, Oscar requests a 1.5 percent adjustment to pay for the cost of a vaccine. It is unlikely that a vaccine will be widely available in 2021. Moreover, even if a coronavirus vaccine were to be widely available, Congress has made clear its intention to engage in cost control and price regulation efforts around such a vaccine.<sup>29</sup> Oscar will most likely be able to take advantage of federally regulated coronavirus vaccine prices for its members.

In addition, Oscar has requested a 3.8 percent adjustment for antibody testing. Oscar further implausibly assumes that 100 percent of its members will request an antibody test in 2021, the same year that it predicts a vaccine will be available. However, Oscar has not provided any adequate support for this predicted utilization in either antibody testing or vaccination in 2021. Indeed, it is unlikely that all or even most Oscar members would elect to receive antibody testing, especially if a vaccine were to become available next year. Antibody testing has not been determined to be a useful measure of immunity.

Oscar’s COVID-19 rate adjustment increase also comes at a time when health plan enrollees in general are delaying elective care due to the pandemic. Most importantly, because Oscar members are healthier than average, it is likely that Oscar members are, on average, more prone than members of other plans to delay care. Due to diminished claims, the pandemic will most likely allow Oscar and QHPs alike to build their reserves, thus belying any need for a 2021 COVID-19 rate adjustment.

HCFANY therefore strongly urges the Department to disallow any adjustment due to COVID-19 across the entire individual market in general, as well as specifically for Oscar.

Thank you for your attention.

Very truly yours,

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<sup>29</sup> HR 6074 (2020) (The coronavirus funding package passed on March 6 specified that if a vaccine is developed it should be priced “fairly and reasonably.”)



A handwritten signature in blue ink, consisting of the first name "Amanda" and the last name "Dunker". The signature is fluid and cursive, written in a dark blue color.

Amanda Dunker  
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Community Service Society of New York