Actors Fund ☙ African Service Committee ☙ Children's Defense Fund-New York
Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center ☙ Hispanic Federation
The Legal Aid Society ☙ 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
South Asian Council for Social Services ☙ Young Invincibles

July 1, 2022

Adrienne A. Harris Superintendent
John Powell, Assistant Deputy Superintendent for Health
Frank Horn, Chief Actuary - Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: Requested Rate Changes – Oscar – OHIN-133239191

Dear Superintendent Harris, Assistant Deputy Powell, and Chief Actuary Horn:

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 is grateful for the opportunity to submit comments on the 2022 rate requests submitted by New York's individual market carriers. We deeply appreciate the Department's annual efforts to keep rates as low as possible through its robust public prior approval process. Below are comments on the individual market applications as a whole, followed by specific comments on Oscar's request.

I. New York's Individual Market

For the past two years, New York's individual market has covered approximately 260,000 people, down from 323,000 in 2019. The pandemic and resulting economic downturn caused a 19% decrease in enrollment in 2021, with many consumers migrating to the Essential Plan and Medicaid thanks to the State's progressive adoption of the federal Public Health Emergency provisions. Twelve carriers are planning to offer insurance in 2023 in the individual market. Only two of the carriers are payers into the risk adjustment program (Fidelis and Oscar), reflecting their relatively healthy enrollment. There were four payers in 2021 and five in 2020.

Table 1. On-Exchange Enrollment in New York's Individual Market, 2017-2022

	Number of People Enrolled	*Percent Change*
2017	309,195	-
2018	317,496	2.7%
2019	323,460	1.9%
2020	322,774	-0.2%

2021	261,242	-19.1%
2022	261,714	0.2%

The individual market carriers are requesting an average 18.2% premium increase (with a range from 6.9% by HealthPlus to 34.6% by the Health Insurance Plan of Greater New York—Emblem). These requests are significantly higher than in recent years. For example, the carriers requested average rate increases of 8.6% in 2022, 11.8% in 2021, and 9.7% in 2020.

Table 2. 2023 Individual Market Rate Requests	
Plan	*Request*
Emblem/HIP	34.6%
CDPHP	28.4%
NYQHC/Fidelis	23.2%
Highmark	20.5%
MVP	19.2%
United	16.1%
Oscar	14.6%
Excellus	14.0%
Healthfirst	13.0%
MetroPlus	12.8%
Independent Health	10.2%
HealthPlus	6.9%
Average	**18.7%**

The carriers' proposed rate increases are national outliers, far surpassing the requests coming in from carriers in other states (see Table 3 below) that have similar or significantly smaller risk pools. Washington and Michigan have comparable individual markets with similar numbers of carriers and risk pools, yet their carriers seek only 7.2% and 6.8% rate increases, respectively. Even the tiny neighboring state of Rhode Island, with just two carriers, is considering an 8% increase. The New York carriers offer no explanation to support relatively large rate increase proposals.

Table 3. Proposed 2023 Rate Increases in State Individual Markets			
	Average Request	*Number of People in Individual Market*	*Number of Carriers (including off-exchange)*
New York	18.8%	251,745	15
Vermont	14.7%	31,582	2
Maryland	11.0%	241,273	5
Rhode Island	8.0%	42,235	2
Washington	7.2%	245,174	14
Michigan	6.8%	339,181	12
Oregon	6.7%	177,813	6

Should the Department grant the proposed increases, New York's consumers would pay extremely high average monthly premiums of $778 (though many people enrolled in individual market plans in New York receive premium subsidies that would insulate them from higher premiums). However, New York's individual market carriers have a history of asking for much larger premium increases than are ultimately approved (see Table 4 below). New York consumers urge the Department to maintain its laudable tradition of reducing the premiums in order to shield consumers from unsupported double digit premium increase requests.

Table 4. Requested Premium Increase vs. Approved Increase

Year	*Requested Change*	*Approved Change*	*Difference*
2022	10.8%	3.6%	-66.7%
2021	8.1%	1.5%	-81.5%
2020	9.7%	7.5%	-22.6%
2019	16.9%	6.3%	-62.7%

A review of the carriers' applications suggests some areas in which the Department can fairly reduce the 2023 rate requests, including closely assessing: their medical loss ratio histories; their estimates about the impact of Covid-19; changes to federal premium subsidies; annual claims trend; administrative costs; and profits and surplus retention.

HCFANY also urges the Department to incorporate its own complaint and quality information into the rate review process. The Department publishes the New York Consumer Guide to Health Insurers each year so that consumers can see which plans perform the best.[1] The report provides data on how many complaints the Department receives for each company, how many coverage appeals are filed and what proportion result in reversals of the plan's decisions, and how often appeals are escalated outside of the company to the State's External Appeal program. When plans have high reversal rates, it sometimes means that they are denying care without any basis and then spending administrative resources on appeals that should not be necessary. The report also shows how well the companies do on performance measures such as access to preventive care or ensuring people with chronic conditions are receiving the care they need. The state should integrate these independent measures of product value into its prior approval review. If plan members are unable to access care, that company should be asked to improve in advance of authorizing large rate increases.

1. Medical Loss Ratios

Similar to plans around the country, New York plans experienced very high profits in 2020, followed by much lower profits in 2021.[2] The plans' medical loss ratios (MLRs) show how much revenue they spent on health care for members as opposed to administrative costs and profit. In 2020, the average MLR was only 85.8% and four plans were at or below the state's minimum 82% (below which the plan must pay rebates). In 2021, the average MLR jumped to 99.8%, and five plans reported an MLR over 100%. That means the plan spent more on health care services than it brought in.

MLRs are assessed over three years for the purposes of calculating rebates, so any rebates the carriers owe individual market consumers in 2022 will be based on MLRs for 2019, 2020, and 2021. When smoothed over three years, the carriers' MLRs are an average of 91.3% (see Table 5 below). Most of the carriers project more typical MLRs for 2022 (an average of 93.6%) and are proposing an average MLR of 87.6% in 2023. The Department approved an average MLR of 87.5% for the 2022 rates. It should continue to reject rate proposals resulting in MLRs below this for 2023.

Table 5. Medical Loss Ratios in New York's Individual Market, 2019-2021

Plan	*2019*	*2020*	*2021*	*Average*
CDPHP	92.4%	95.5%	104.3%	97.4%
Health Insurance Plan of Greater New York	87.6%	82.0%	93.9%	87.8%
Excellus	83.0%	84.0%	97.5%	88.2%
Fidelis	78.0%	79.6%	91.7%	83.1%
Healthfirst	87.3%	84.5%	103.2%	91.7%
HealthPlus	88.3%	68.3%	83.1%	79.9%
Highmark	90.8%	90.8%	110.1%	97.2%
IHBC	74.6%	77.2%	104.8%	85.5%
MetroPlus	85.4%	87.7%	113.8%	95.6%
MVP	95.5%	101.1%	99.4%	98.7%
Oscar	96.0%	90.8%	99.2%	95.3%
UnitedHealthCare	99.8%	88.1%	96.7%	94.9%
Average	**88.2%**	**85.8%**	**99.8%**	**91.3%**

2. Impact of Covid-19

Overall, the carriers are reducing rates by 1.7% to reflect projected lower costs related to Covid-19. These downward adjustments are necessary because the claims data being used to estimate 2023 rates is from 2021, and likely includes direct and indirect Covid-related costs that will differ in 2023. All of the carriers expect that direct Covid-19 claims, those related to testing and treatment, will decrease in 2023 as compared to 2021. This is because Covid-19 vaccinations did not become available to all people until several months into 2021 and there are also now treatments that lessen the severity of the disease and reduce complications. Indirect Covid-19 claims are those related to deferred care, which would lower 2021 claims costs for at least part of the year.

The carriers vary widely in how they think possible deferred care in 2021 should be factored into their 2023 rates. Six carriers are adjusting their 2023 rates upwards in relation to indirect Covid-19 costs, which means they believe 2021 claims costs were lower than normal because people were continuing to avoid the health care system. Four of those adjustments are less than 1%. Four carriers include no adjustment, and three include a downward adjustment. Those carriers may assume that their 2021 claims costs were inflated because of people receiving

care deferred during 2020. Some of these overall adjustments are much larger than others. For example, Fidelis is adjusting premiums downwards by 5.7%.

The Department should adopt a consistent policy regarding Covid-19 adjustments across all plans. It should consider whether the other plans have reduced premiums sufficiently to reflect reductions in the impact of Covid-19. It should also look at the methodologies carriers are using to determine the effect deferred care in 2021 will have on 2023 rates, given the variation in their estimates.

Table 6. Covid-related Rate Adjustments			
	Direct Covid	*Indirect Covid*	*Combined*
CDPHP	-0.3%	-0.5%	-0.8%
HIP/Emblem	-2.5%	0	-2.5%
Excellus	-0.7%	0	-0.7%
Fidelis	-1.1%	-4.6	-5.7%
Healthfirst	-2.0%	0	-2.0%
HealthPlus	-5.1%	1.9%	-3.2%
Highmark	-2.8%	0.6%	-2.2%
IHBC	-0.4%	0	-0.4%
MetroPlus	-1.4%	0.8%	-0.6%
MVP	-0.54%	-0.92	-1.5%
Oscar	-4.5%	3.4%	-1.1%
United	-8.3%	8.7%	0.4%
Average	**-2.5%**	**0.8%**	**-1.7%**

3. Enhanced Federal Subsidies

The American Rescue Plan Act (ARPA) increased the amount of premiums available for people purchasing individual market plans and for the first time extended premium subsidies to people earning between 400% and 600% of the federal poverty level. In New York, that meant 147,000 people paid much less for individual market plans than before—the average increase in subsidies was over $1,000.[3] Carriers reduced their 2022 rates in anticipation that increased subsidies would bring new customers and improve the risk pool, on average by 3.7%. Some carriers likely benefited more than others from the larger subsidies.

The enhanced subsidies provided through ARPA are set to sunset in 2023. Some of the carriers have built in rate increases in anticipation of losing customers once their premium costs go up (see Table 7 below). The Department should not allow adjustments made based on speculative judgments about future federal policy changes that may not happen.

If the Department allows these adjustments, it should ensure that these rate increases are based on the carrier's actual experience with the enhanced subsidies. For example, HealthPlus included an upward adjustment of 1%. However, HealthPlus is an HMO and the most expensive

plan on the market. It seems unlikely that price sensitive consumers would flock to HealthPlus in significant numbers due to increased subsidies that would not have covered the cost of its plans.

Table 7. Effect of the Loss of Federal Subsidies	
Plan	*Percent Change in Premium Costs*
CDPHP	1.7%
HIP/Emblem	0
Excellus	0.2%
Fidelis	3%
Healthfirst	0
HealthPlus	1%
Highmark	0
IHBC	0
MetroPlus	-1.3%
MVP	0
Oscar	3.0%
United	0
Average	**0.6%**

The Department should also consider that any impact of the potential termination of the ARPA subsidies will likely be more than offset by new enrollment related to the end of the Public Health Emergency. Many of the people who left the individual market in 2020 ended up in Medicaid plans. When the public health emergency ends, Medicaid redeterminations will begin again for the first time in over two years. People whose 2023 income makes them ineligible for Medicaid will likely enroll in individual market coverage. In fact, the UnitedHealthcare submission estimates that Medicaid redeterminations will increase enrollment by 20% and includes a downwards adjustment to its rate request of 1.1%.

4. Medical Trend

New York's carriers provide a variety of estimates of medical trend, which is an estimate of how much their claims will increase based on changes in prices and utilization. On average, New York's individual market carriers seek a 7.3% medical trend.

Table 8. Estimated 2023 Medical Trend by Carrier, New York	
Carrier	*Estimated Medical Trend*
HIP/Emblem	14.8%
United	8.4%
CDPHP	8.3%
MetroPlus	7.8%
HealthPlus	7.2%
Fidelis	7.0%

Highmark	7.0%
MVP	6.9%
Healthfirst	5.6%
Oscar	5.6%
Excellus	4.7%
IHBC	3.9%
Average	**7.3%**

New York carriers' trend projections are significantly higher than what carriers are projecting in the other states for which this information is available (see Table 9 below). Even the far less competitive market of Vermont, which has just two individual market carriers, projects a lower average medical trend than New York.

Table 9. Estimated 2023 Medical Trend by State	
State	*Estimated Medical Trend*
New York	7.3%
Vermont	7.0%
Washington	6.0%
Oregon	5.7%
Maryland	4.5%

The Department has an important role in controlling medical cost inflation. To this end, it should impose greater standardization in medical trend estimates within New York. There is significant variation in the trend estimates among the carriers, from 3.9% to 14.8% (see Table 8 above). The carrier estimating the lowest trend, Independent Health, is one that might be expected to have one of the higher trend estimates because it is an EPO and serves a relatively small number of consumers. The carrier with the highest estimated medical trend, the Health Insurance Plan of Greater New York (Emblem), is a major New York City HMO that covers hundreds of thousands of City employees and should be able to better control its individual market business trend given its enormous negotiating power with providers.

In setting the 2022 rates, the Department protected consumers' interests by approving an average trend rate of 5.9%. It should consider capping medical trend at this level for 2023 to be more in line with other states. That would mean reducing rate increases for eight plans, since four plans already estimate trends under 5.9%.

5. Administrative Costs and Profit

Administrative costs and profit are another area in which there is excessive variation in carriers' rate applications. On average, the carriers expect 11.3% of their rates to go toward administrative costs (see Table 10 below). Independent Health expects the biggest proportion to go toward administrative costs, at 15.9%. MetroPlus expects the lowest, at 7.4%. For 2022, the Department allowed administrative requests as high as 14%. This is too high. It should consider instead capping administrative costs at 11.3%, the average.

Table 10. Administrative Costs vs Profit		
Carrier	*Projected Administrative Costs*	*Requested Profit/Surplus*
Independent Health	15.9%	1.0%
Healthfirst	14.7%	0.5%
HIP/Emblem	13.2%	2.0%
Fidelis	12.4%	1.5%
Excellus	12.2%	1.5%
CDPHP	11.5%	1.0%
United	9.8%	1.5%
HealthPlus	9.6%	2.0%
Highmark	9.0%	1.0%
Oscar	8.3%	3.0%
MetroPlus	7.4%	0.5%
Average	**11.3%**	**-**

Profit and surplus requests range from 3% to 0.5%. The Department capped profit and surplus at 0.5% for the 2022 rates. It should do the same for 2023.

II. Oscar

Oscar is a for-profit EPO serving the New York City and Long Island regions. Oscar used to be one of the largest carriers in New York's individual market, with a peak membership in 2018 of more than 50,000 members. But between 2020 and 2021, it lost a third of its membership and just 16,899 members remain. This downward enrollment decline continued last year, when it lost over 6,000 members. Oscar is one of two plans making a payment into the federal risk adjustment program, an estimated 16%.

Oscar seeks a 14.6% rate increase for 2022, which is lower than the average 18.2% request. However, this year the rate requests are much higher than normal. If this rate increase is approved in total, its new rates will be $786 a month—which appears extremely high for such a limited network product.

Oscar's medical trend and administrative costs are lower than average. It also has experienced high MLRs over the past three years. However, it may be underestimating the reduction in costs it will experience as Covid-19 claims stabilize. It is also asking for more profit than any other carrier, includes a 3.0% increase in anticipation of federal policy changes that may not happen and has included a 5.2% increase due to morbidity in the general population that the other carriers are not projecting.

1. Oscar's overall adjustment related to the pandemic's decreasing severity is 1.1%.

Oscar estimates that direct Covid-19 claims costs will decrease, resulting in a 4.5% downward adjustment, and that non-Covid-19 claims related to deferred care will increase, resulting in a 3.4% upward adjustment. Altogether it is adjusting its rate request downward by 1.1%. This is below the average 2.5% reduction. Separately, Oscar's direct and indirect Covid-19 adjustments are much larger than average. The Department should consider reviewing Oscar's Covid-19 assumptions along with those of the other carriers because of how much they differ. It may be that the Department can standardize some of these adjustments.

2. **Oscar should not receive an increase in anticipation of a reduction in federal premium subsidies which may not happen.**

Oscar seeks a 3% upward adjustment to its rate proposals in anticipation of losing the enhanced federal premium subsidies created through the American Rescue Plan Act (ARPA). This is the largest increase proposed in relation to the subsidies. The Department should examine the effect the subsidies had on Oscar more closely to determine whether it will really experience a larger effect from their expiration than other plans in New York. Further, the enhanced subsidies could be renewed, which makes this increase speculative. Plans should not be granted ARPA-related increases unless the enhanced subsidies actually expire. If this adjustment is allowed, and the enhanced subsidies are renewed, members should not have to keep paying the higher rates.

Moreover, even if the subsidies were to expire, the end of the Public Health Emergency will mean that thousands, potentially tens of thousands, of New Yorkers will migrate from Medicaid or Essential Plan products to Qualified Health Plans. Oscar might benefit from some patients switching to it from these products. Accordingly, no adjustment should be provided for the potential elimination of ARPA subsidies.

3. **Oscar's 3% profit request should be reduced to 0.5%.**

No other carrier asked for more than 2% in profit or surplus. Oscar's 3% profit request should be reduced to 0.5% for two reasons. First, the Department has wisely adopted 0.5% as the allowed profit or surplus for the past few years. Second, Oscar should not be permitted to receive more in profits than any other carrier while expecting its members to absorb a double-digit rate increase.

4. **Oscar's morbidity and enrollment assumptions should be carefully reviewed.**

In its Actuarial Memo, Oscar says that increased morbidity will increase rates in 2023 by 5.2% because it expects further decline in its own membership which means a smaller risk pool. This assumes that the remaining members will be sicker than the members who leave. Only two other plans include a morbidity adjustment and these are much smaller (1.1% and 1%). Further, Oscar has included increases due to reduced membership in two other places in its Exhibits: the 3% increase due to the reduction in federal premium subsidies and 4.9% in line 24 of Exhibit 18 (explained as "change in demographics" and described as "member movement" in its Actuarial Memo). Altogether Oscar is arguing that membership declines and changes require a 15.9% upward adjustment in its 2023 rates.

These morbidity adjustments will become a self-defeating prophecy if allowed. Oscar is already losing members faster than any other plan—its membership declined by 27% between 2021 and 2022. This is likely because the Department has permitted it to significantly increase its rates over the past three years—for example, by 11% in 2019 and 14% in 2020. A rate increase of 14.6% will drive even more members out of the plan. Other plans are controlling costs better and growing or have stabilized their enrollments. Further, as Oscar mentions in its Actuarial Memo, when the public health emergency ends and Medicaid redeterminations begin again, more people will join the individual market. In its filings, Oscar fails to explain the impact of the end of the public health emergency and how it could impact its rates. The Department should consider the possibility that these new potential individual market members may benefit Oscar more than it anticipates.

5. Oscar's quality and complaint data

Despite its small membership, Oscar performs poorly on quality and complaint measures. For example, the Department ranks it 13 out of 15 in both consumer and prompt pay complaints in its Consumer Guide.[1] It performs extremely poorly on access to care and service measures, possibly reflecting its very small network of providers.[2] In fact, Oscar appears to perform poorly on nearly all quality measures according to the Department's Consumer Guide, including: child and adolescent health; adult health (flu shots, colon cancer screening, BMI assessments); nearly all women's health measures; diabetes care; and many behavioral health measures (follow up after emergency room or hospital admissions). Oscar only appears to do well on the measures that are unrelated to Oscar itself (e.g. satisfaction with providers).

The Department should consider and integrate these patient-centered factors into its consideration of Oscar's rate application.

Thank you for your attention.

Very truly yours,

Amanda Dunker
Health Policy Director
Community Service Society of New York

[1] https://www.dfs.ny.gov/system/files/documents/2021/08/ny_consumer_guide_health_insurers_2021.pdf (pages 6 and 11).
[2] https://www.dfs.ny.gov/system/files/documents/2021/08/ny_consumer_guide_health_insurers_2021.pdf (page 31).