African Service Committee ○ Children's Defense Fund-New York
Coalition for Asian American Children + Families ○ Community Service Society of New York
Consumers Empire Justice Center ○ Entertainment Community Fund ○ 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 ○ 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

June 28, 2023

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 – Emblem - HPHP-133665636

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 2024 rate requests submitted by New York's individual market carriers. HCFANY deeply appreciates the Department's annual efforts to keep rates as low as possible through its robust public prior approval process. The comments below are divided into sections: (I) General comments regarding New York's individual insurance market; and (II) specific comments on Emblem's request.

I. General Comments Regarding New York's Individual Market Conditions

Health insurance and health care are a major part of most New Yorkers' budgets, and something over which consumers have poor information and limited freedom of choice. This year, the carriers seek an extraordinary 20 percent on average rate increase, which represents hundreds of millions of dollars for New York's consumers. Public rate review provides some balance of power between consumers and carriers, and carriers must be expected to follow both the letter and the spirit of the law. That means providing transparent, reasonable justifications supported by evidence to receive rate increases.

HCFANY recognizes the need for carriers to adjust for legitimate administrative expenses and reasonable medical trend increases. Many of the 2024 applications are opaque and rely on hidden assumptions. Indeed, most of New York's carriers have failed to provide adequate explanations for their requests. HCFANY urges the Department to scrutinize the carriers' respective actuarial memoranda closely and provide feedback about the transparency of their

assumptions. Rate increases should be rejected or pared back whenever inadequate information is provided in the carriers' actuarial memoranda.

This general comment section describes the following conditions that are likely to influence the rates for the 2024 coverage year: (A) recent enrollment and rate request trends; (B) New York's requests in the context of its peer states; (C) the impact of the State's 1332 Waiver on enrollment; (D) the impact of the end of the Public Health Emergency's continuous enrollment rules and other Covid-19 impacts; (E) the likely decline of Medical Loss Ratios due to the reduction in pent up demand utilization in the individual market; (F) the overstatement of medical trend; (g) elevated administration and cost projections; and (h) the need to better integrate the Department's access and quality data.

A. New York's individual market recent enrollment patterns and requests trends

New York's individual market covers approximately 250,000 people, down from 323,000 in 2019 (see Table 1).[1] The pandemic and resulting economic downturn, (in which unemployment increased from 4.1 percent in February 2020 to a peak of 16.6 percent in May 2020 in New York State) caused a 19 percent decrease in enrollment between 2020 and 2021. Many consumers migrated to the Essential Plan and Medicaid due to the State's effective implementation of the federal Public Health Emergency (PHE) provisions regarding continuous open enrollment and automatic renewal of public coverage.

Between 2022 and 2023, the individual market decreased by another 5 percent, reflecting the impact of the maintenance of continuous enrollment in public coverage under the PHE and a return to employer-sponsored coverage with record-levels of employment (4 percent as of April 2023).[2]

Table 1. On-Exchange Enrollment in New York's Individual Market, 2017-2023

	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%
2023	248,202	-5.2%

In 2024, 12 carriers seek to offer insurance in the individual market, indicating a robust and lucrative market. The individual market carriers are requesting a weighted average of a 20.4

[1] "2024 INDIVIDUAL AND SMALL GROUP REQUESTED RATE ACTIONS: Exhibit 18, Line 55." *2024 – DFS Portal*, myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/additional-information-2024.

[2] "Unemployment Rate in New York." *FRED*, 23 May 2023, fred.stlouisfed.org/series/NYUR.

percent premium increase, even higher than last year's remarkable 18.2 percent average request. These requests are far higher than requests from previous years: 8.6 percent in 2022; 11.8 percent in 2021, and 9.7 percent in 2020. The 2024 requests are also concerning because they range from 13.3 percent by MVP to a shocking 52.8 percent by Emblem. By contrast, the 2023 range was significantly smaller (6.9 percent to 34.6 percent).

Table 2. 2024 Individual Market Rate Requests		
Plan	*2023 Plan Members*	*2024 Proposed Rate Increase*
Emblem/HIP	7,147	52.75%
Independent Health	10,603	39.20%
CDPHP	5,210	23.50%
MetroPlus	11,598	23.39%
Highmark	6,612	22.58%
United	6,127	20.95%
Healthfirst	30,726	20.88%
HealthPlus	18,929	20.72%
Oscar	12,868	18.41%
NYQHC/Fidelis	90,250	18.15%
Excellus	25,677	15.19%
MVP	22,050	13.29%
Total Members/ Weighted Average Request	247,797	20.40%

New York's individual market carriers have a history of seeking much larger premium increases than are ultimately approved (Table 3 below). The Department should endeavor to maintain this laudable tradition of reducing the premiums in order to shield consumers from double digit premium increase requests. Premium increases should be based on concrete evidence about the nature of costs and the carriers' diligent efforts to control them. Many of the 2024 requests fail to provide adequate evidence to support their rate demands.

Table 3. Requested Premium Increase vs. Approved Increase			
Year	*Requested Change*	*Approved Change*	*Difference*
2023	*18.2%*	*9.1%*	*-50.0%*
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%

B. **New York's rate requests far surpass those of its peer states.**

The New York carriers' proposed rate increases are national outliers, far surpassing the requests of carriers in other states that have similar or significantly smaller risk pools. (Table 4 below.) New York is a large state, with the most carriers, yielding a highly competitive market. As a result, New York State is well positioned to control prices that would discourage New Yorkers from purchasing coverage on the individual market.

Washington and Michigan have comparable individual markets with similar numbers of carriers and risk pools, yet their carriers seek only 9.1 percent and 5.6 percent average rate increases, respectively. Only Oregon has a reinsurance program that supports its premium cost controls.[3] It is also notable that CMS approved a 2.1 percent increase for Medicare Advantage plans for 2024. New York carriers offer no justification as to why their premiums are so much higher than those requested in peer states.

Table 4. Proposed 2024 Rate Increases in State Individual Markets

	Average Request	*Number of People in Individual Market*	*Number of Carriers (including off-exchange)*
New York	20.9%	248,202	12
Vermont[4]	14.5%	30,119	2
District of Columbia[5]	12.3%	12,749	3
Connecticut[6]	12.4%	110,375	3
Washington[7]	9.1%	250,000	14
Michigan[8]	5.5%	404,419	12
Maryland[9]	5.7%	471,000	4
Oregon[10]	6.2%	169,525	6
Medicare Advantage[11]	2.1%	n/a	n/a

[3] State Health Access Data Assistance Center, https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers

[4] "Rate Review Home Page." *Vermont.Gov*, ratereview.vermont.gov/.

[5] "Proposed Rates for January 2024 Health Plan Offerings on DC Health Link." *DISB*, disb.dc.gov/2024rates.

[6] "Health Insurance Rates for 2024." *Connecticut Insurance Department*, 2023, www.catalog.state.ct.us/cid/portalApps/HCfiling2024.aspx.

[7] "Fourteen Insurers Request Average 9.11% Rate Change for 2024 Individual Health Insurance Market." *Office of the Insurance Commissioner Washington State*, 2023, www.insurance.wa.gov/news/fourteen-insurers-request-average-911-rate-change-2024-individual-health-insurance-market?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=.

[8] *Serff Filing Access - Michigan*, filingaccess.serff.com/sfa/search/binderSearchResults.xhtml.

[9] "Health Carriers Propose Affordable Care Act (ACA) Premium Rates For ..." *Maryland Insurance Administration*, 9 June 2023, insurance.maryland.gov/Documents/newscenter/newsreleases/ACA-Premium-Rates-Proposed-2024-6122023.pdf.

[10] "Health Insurance Companies File 2024 Health Insurance Rate Requests for Individual and Small Group Markets." *Division of Financial Regulation : Health Insurance Companies File 2024 Health Insurance Rate Requests for Individual and Small Group Markets : 2023 News Releases : State of Oregon*, dfr.oregon.gov/news/news2023/Pages/20230518-2024-health-insurance-rates.aspx.

[11] "2024 Advance Notice." *CMS.Gov*, www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/announcements-and-documents/2024-advance-notice.

Should the Department grant the proposed increases, the average monthly premiums would range from $701 to $1423 with a weighted average of $790.[12] Many people, 61 percent, receive premium subsidies through the Affordable Care Act and the Inflation Reduction Act that will insulate them from some of the premium increase.[13] However, almost 39 percent do not receive subsidies and pay full price, and high premiums lower the purchasing power provided by subsidies.

C. **Impact of the State's 1332 Waiver request on 2024 premiums should not be overestimated.**

All the carriers seek a rate increase related to the expansion of the Essential Plan under the 1332 State Innovation Waiver, which was filed with the federal government on May 12, 2023. This Waiver seeks to expand the Essential Plan from its current income eligibility cap from 200 to 250 percent of the federal poverty level. According to State estimates, 70,000 people would migrate to the Essential Plan from the individual market, causing a .5 to 2.2 percent rate increase for remaining individual market members.[14]

For the following reasons, the expansion of the Essential Plan under the 1332 State Innovation Waiver necessitates either no upward adjustment at all, or only a conservative adjustment that is consistent with the State's own public estimates about the impact of the Waiver on New York's individual market: (1) an improper reliance on non-public estimates about the premium impact of the waiver; (2) the speculative assumption that the Waiver will be approved and implemented for the entire calendar year 2024; and (3) a lack of carrier-specific income eligibility data for their members.

First, the State has publicly issued a "conservative" estimate in its federal Waiver filing that the premium impact of the 1332 Waiver "is estimated between .5 percent and 2.2 percent."[15] However, the carriers' submissions indicate that the Department has prepared a conflicting estimate of a 3.2 percent premium impact in an analysis apparently shared solely with the carriers. This analysis may be distorted because it relies on claims data solely from an outlier coverage year – 2022. In 2022, there were fewer enrollees in the individual market. Additionally, those who remained were sicker (due to Covid) and were likely utilizing care at a higher level because of the combined phenomena of higher utilization and pent-up demand from prior pandemic years.

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[12] "2024 INDIVIDUAL AND SMALL GROUP REQUESTED RATE ACTIONS: Exhibit 18, Line 56." *2024 - DFS Portal*, myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/additional-information-2024.

[13] "Health Insurance Coverage Update: Impact of ARPA Subsidies." p.6, *NYSOH Enrollment Data*, Apr. 2023, info.nystateofhealth.ny.gov/enrollmentdata.

[14] "Health Insurance Coverage Update: Impact of ARPA Subsidies." p.6, *NYSOH Enrollment Data*, Apr. 2023, info.nystateofhealth.ny.gov/enrollmentdata.

[15] "NY 1332 Waiver Application." p. 25, *NY State of Health*, info.nystateofhealth.ny.gov/sites/default/files/American%20Rescue%20Plan%20Fact%20Sheet%20-%20English.pdfltclid=.

More importantly, any analysis that the Department provides to the carriers for the purpose of generating their prospective rates should be simultaneously shared with the public to ensure a transparent rate review process. In addition, assumptions governing the State's rate decisions should be consistent with the publicly disclosed estimates filed with the federal government in its Waiver application. To rely on private, in lieu of public, analytics undermines the transparency and integrity of both the Department of Financial Services and a robust public prior approval process.

Second, it is unclear whether any adjustment should be made based on the speculative assumption that the Waiver will be approved for the entire 2024 plan year. The State only filed the application in mid-May, and several procedural steps need to occur before any approval is likely to come down from the U.S. Department of Health and Human Services (HHS), including: a "Completeness Review" by HHS and the Treasury Departments (45 days); a Federal Comment Period (30-days); and the Application Review process conducted by HHS and Treasury Departments (180 days). In short, the Waiver is unlikely to be approved in less than eight months – well into the next calendar year.[16] Given this uncertain timing, any adjustment for the Waiver should be delayed until 2025 when the State has certainty about whether the Waiver has been approved and when it is actually implemented.

Third, the Waiver only impacts plan members who fall between the expanded income eligibility cap of 200 to 250 percent of the federal poverty level. Only one carrier, Healthfirst, was forthcoming about the percentage of their membership that would be impacted by the Waiver.[17] If the Department allows an upward adjustment in 2024 related to the Waiver, the adjustment should be made in a manner that reflects the relative target membership of the respective carriers.

For example, it seems unlikely that the high-cost CDPHP has a significant number of Waiver-eligible members, yet it is seeking an unsubstantiated 5.9 percent increase due to its anticipated decline in members with incomes between 200-250 percent of FPL. By contrast, the lower-cost, H+H-sponsored MetroPlus seeks only a 1.6 percent adjustment. Given their premium differentials and members' price sensitivity, it is highly likely that MetroPlus would witness a larger decline in the relevant income cohort than CDPHP.

Accordingly, the Department should design and implement a coherent allocation based on the carriers' respective enrollee cohorts.

Table 5. Adjustments for the Impact of the 1332 Waiver to Expand the Essential Plan	
CDPHP	5.9%
Fidelis	3.2%

[16] Center for Medicaid & Medicare Services, "Steps for States Considering a 1332 Waiver," May 2019, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Steps-for-States-Considering-A-1332-Waiver.pdf

[17] "2024 INDIVIDUAL AND SMALL GROUP REQUESTED RATE ACTIONS: Actuarial Memo, Healthfirst, p. 8." *2024 - DFS Portal*, myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/additional-information-2024.

IHBC	3.2%
MVP	3.2%
United	3.1%
HIP/Emblem	2.9%
Healthfirst	2.9%
HealthPlus	2.9%
Oscar	2.8%
MetroPlus	1.6%
Excellus	1.3%
Highmark	0.5%
Average	**2.8%**

Given the speculative nature of the Waiver's approval and its timing, the Department should award no adjustment, a pro-rated adjustment, or at the very least, an adjustment that has been publicly disclosed and filed with the federal government and the public.

D. **The end of the Covid-19 Public Health Emergency requires a downward adjustment.**

The end of the Covid-19 Public Health Emergency (PHE) necessitates a downward adjustment for four reasons: (1) the end of the continuous coverage requirements under the federal PHE means increased healthy (lower-income) individual market membership; (2) the amelioration of Covid-19's morbidity in enrollees; (3) the dissipation of demand for deferred care; and (4) the elimination of cost-sharing protections for Covid-19 care will diminish claims utilization.

First, the Department asked carriers to estimate the impact the unwinding of the PHE's continuous coverage rules would have on individual market enrollment. During the pandemic, New York stopped requiring people in public health insurance programs to renew (which requires verifying income). Between 2020 and 2021, nearly 62,000 people left the individual market while 1.7 million and 328,000 more people enrolled in Medicaid and the Essential Plan, respectively.

Altogether 9.3 million New Yorkers are now renewing their coverage for the first time since 2020 and are doing so in an economy that is greatly improved.[18] Medicaid and Essential Plan renewal over the next year (June 2023 – June 2024) will reveal higher incomes for many people, making them no longer eligible for public coverage. According to New York State of Health Marketplace officials, Qualified Health Plan (QHP) enrollment is already up by 5,324 people for the very first renewal period, between May 15 to June 15, 2023.[19] If this early rate of

[18] New York State Department of Health, "New York Public Health Emergency and Continuous Coverage Unwind Plan, May 10, 2023, slide 3, available at: https://info.nystateofhealth.ny.gov/sites/default/files/NYHealth%20Webinar%20-%20Keeping%20New%20Yorkers%20Covered.pdf

[19] Department of Health correspondence with the authors, June 14, 2023.

QHP enrollment is maintained, an additional 70,000 people would return to the individual market in 2024.

Expert researchers at the Urban Institute have arrived at a similar conclusion. The Urban Institute estimates that over one million people will lose Medicaid coverage in New York State as a result, and that 5.5 percent of people losing Medicaid (about 60,000 for New York) will join the individual market.[20] The Urban Institute experts indicate that states like New York that operate their own Marketplaces will be able to seamlessly assist people formerly receiving public insurance to return to the individual market.[21] The return of younger and healthier Medicaid and Essential Plan enrollees will be beneficial for New York's individual market.

By contrast, the carriers' rate adjustments and supporting actuarial memoranda displayed confusion and inconsistency. Two carriers (HealthPlus and United) requested a positive adjustment, while five carriers noted a downward adjustment, and the other five made no adjustment at all for the end of the PHE. One carrier (Independent Health) did not seem to understand the question, failing to acknowledge the termination of the continuous coverage requirement. The Department should address this confusion by providing a uniform negative adjustment that reflects the likely return of at least 70,000 enrollees to the individual market.

Table 6. Impact of the Unwinding Public Health Emergency (PHE) Rate Adjustments	
MetroPlus	-4.8%
Oscar	-2.2%
Healthfirst	-1.0%
MVP	-0.3%
IHBC	-0.2%
CDPHP	0.0%
HIP/Emblem	0.0%
Excellus	0.0%
Fidelis	0.0%
Highmark	0.0%
United	0.4%
HealthPlus	1.6%
Average	**-0.03%**

Second, the carriers' submissions—citing 2022 claims data—continue to assert that they should be offered an upward adjustment for Covid-19, principally due to the increased costs of

[20] Matthew Buettges and Andrew Green, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," December 2022, Urban Institute, https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage.

[21] Urban Institute, "What will happen to Medicaid enrollees' health coverage after the Public Health Emergency?: Updated Projections," March 2022, https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf.

vaccinations and increased utilization related to pent-up demand for deferred care. But these assertions should be discounted since Covid-related morbidity and care has declined and is likely to continue to decline in the 2024 plan year.

The CDC marked the end of the Covid-19 Public Health Emergency (PHE) in May 2023. The prevalence and severity of Covid-19 cases across the country, and in New York State specifically, has decreased substantially. In New York, the seven-day test positivity rate hit an all-time high of 22.2 percent in January 2022, then dropped to 1 percent within a month, and has stayed steadily under 10 percent ever since.[22] In addition to the decreased prevalence of positive Covid test results, the CDC notes that as of May 2023, there are "more tools and resources than ever before to better protect ourselves and our communities."[23] In light of this evidence of declining Covid-related morbidity, the Department should adopt a uniform downward adjustment.

Third, it is important to understand that the carriers were still witnessing inflated utilization in their 2022 claims data as people caught up on deferred care that was not possible during the worst of the pandemic. In short, the end of the Covid-19 PHE marks a fundamentally different point in the pandemic than what is reflected in the 2022 claims data relied upon by the carriers.

Fourth, for the 2024 plan year, the Department asked carriers to estimate the impact of change in expected unit cost and utilization of Covid-19 testing and vaccination. Last year, the Department asked for a more comprehensive accounting of the impact of Covid-19 including an adjustment for inflated claims data. As described above, the cost of Covid-19 treatment in 2024 is expected to be significantly lower than the 2022 data would suggest because of the combined reduction in frequency and severity of Covid-19 cases in New York.[24] Moreover, utilization is likely to decline because of the Department's Circular Letter to the carriers which re-implements cost-sharing for Covid-19 testing and treatment, effective May 2023.[25] Extensive research documents that even small amounts of cost-sharing reduce health care utilization.[26]

Table 7. Covid-19 Testing and Vaccination Unit Cost and Utilization Rate Adjustments	
HealthPlus	-1.1%

[22] "Positive Tests over Time, by Region and County." *Department of Health*, coronavirus.health.ny.gov/positive-tests-over-time-region-and-county.

[23] "End of the Federal COVID-19 Public Health Emergency (PHE) Declaration." *Centers for Disease Control and Prevention*, www.cdc.gov/coronavirus/2019-ncov/your-health/end-of-phe.html#:~:text=The%20federal%20COVID%2D19%20PHE,to%20align%20with%20data%20changes.

[24] "Covid-19 Daily Hospitalization Summary." *New York State Department of Health*, coronavirus.health.ny.gov/daily-hospitalization-summary.

[25] "Insurance Circular Letter No. 3 (2023): Coverage of Covid-19 Testing and Immunization Following the Expiration of the Federal Public Health Emergency." *Department of Financial Services*, www.dfs.ny.gov/industry_guidance/circular_letters/cl2023_03.

[26] "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings." *KFF*, 30 Jan. 2018, www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

Healthfirst	-1.0%
HIP/Emblem	-0.8%
Fidelis	-0.8%
MetroPlus	0.0%
Oscar	0.0%
Excellus	0.0%
Highmark	0.1%
CDPHP	0.1%
IHBC	0.1%
United	0.2%
MVP	0.5%
Average	**-0.03%**

Accordingly, the Department should approve a much more aggressive negative adjustment than those described by the carriers in Table 7 to accurately reflect the change in costs and utilization of Covid-19 related services amongst individual market members in the 2024 plan year.

E. **Medical Loss Ratios**

Consistent with the experience of carriers throughout the United States, New York plans experienced very high profits in 2020, followed by much lower profits in 2021 and 2022. The carriers' 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 percent, and four plans were at or below the State's minimum 82 percent (below which the plan must pay rebates). In 2022, the average MLR was 101.9 percent, meaning the plans spent more on health care services than they received in premium revenues.

Table 8. Medical Loss Ratios in New York's Individual Market, 2019-2022

Plan	*2019*	*2020*	*2021*	*2022*	*Average*
CDPHP	92.4%	95.8%	112.2%	103.5%	103.8%
Health Insurance Plan of Greater New York	87.6%	82.0%	95.6%	104.6%	94.1%
Excellus	83.0%	84.0%	97.5%	99.6%	93.7%
Fidelis	78.0%	79.6%	89.4%	104.2%	91.1%
Healthfirst	87.3%	84.5%	103.2%	92.1%	93.3%
HealthPlus	88.3%	69.0%	80.4%	108.6%	86.0%
Highmark	90.8%	90.8%	108.6%	115.5%	105.0%
IHBC	74.6%	77.2%	100.7%	112.2%	96.7%
MetroPlus	85.4%	87.7%	113.8%	102.2%	101.2%

MVP	95.5%	101.1%	99.0%	91.8%	97.3%
Oscar	96.0%	91.6%	99.2%	91.0%	93.9%
United	99.8%	88.1%	96.7%	97.5%	94.1%
Average	**88.2%**	**86.0%**	**99.7%**	**101.9%**	**95.8%**

However, high medical loss ratios do not necessarily mean the carriers need large rate increases for 2024. Some of the carriers are asking for rate adjustments that would give them very low medical loss ratios in 2024. For example, Emblem is requesting a 53 percent rate increase so that it can lower its expected medical loss ratio in 2024 to 84 percent from the 105 percent it is reporting for 2022. Emblem should not ask consumers to bear such a large rate increase to achieve this low MLR. Instead, it should aim for a gentler increase that will more slowly get its MLR back to normal. Further, some plans with very high MLRs in 2022 are already estimating that their MLR will be lower in 2023.

Table 9. Medical Loss Ratio by Carrier, New York		
Carrier	*Projected 2023 MLR*	*Projected 2024 MLR*
Highmark	102.6%	90.5%
United	97.9%	89.9%
MetroPlus	90.9%	89.9%
HealthPlus	85.4%	88.9%
CDPHP	95.6%	89.6%
Oscar	91.3%	88.5%
Excellus	90.7%	87.8%
Healthfirst	89.8%	86.7%
MVP	87.6%	86.6%
Fidelis	97.2%	84.7%
Independent Health	105.2%	84.0%
HIP/Emblem	104.8%	82.1%
Average	**95.6%**	**87.5%**

Accordingly, the Department should proceed cautiously when estimating appropriate MLRs for the 2024 plan year.

F. **Medical trend**

New York's carriers provide a variety of estimates of medical trend that indicate that they do little to control health care costs over time. Medical trend is an estimate of how much their claims will increase based on changes in prices and utilization. The promise of insurance is that it aggregates its enrollees' bargaining power to control price negotiations with providers, drug makers, and medical equipment manufacturers. On average, New York's individual market carriers seek a 7.6 percent medical trend.

Table 10. Estimated 2024 Medical Trend by Carrier, New York	
Carrier	*Estimated Medical Trend*
HIP/Emblem	14.2%
HealthPlus	9.0%
Highmark	9.0%
United	8.8%
MetroPlus	8.3%
CDPHP	7.9%
MVP	7.8%
Healthfirst	6.2%
Oscar	5.8%
Excellus	5.5%
IHBC	5.2%
Fidelis	3.1%
Average	**7.6%**

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 3.1 percent to 14.2 percent (see Table 10 above). The carrier with the highest estimated medical trend, 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 2024 rates, the Department should protect consumers' interests by approving an average consistent with average estimated medical trend amongst New York carriers as well as the national projected health expenditures for 2024 of 7.6 percent.[27]

G. **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 11.5 percent of their rates to go toward administrative costs (Table 11). Independent Health expects the biggest proportion to go toward administrative costs, at 17 percent. Highmark expects the lowest, at 3.1 percent. The Department should consider capping administrative costs at 11.5 percent, the average.

Table 11. Administrative Costs vs Profit		
Carrier	*Projected Administrative Costs*	*Requested Profit/Surplus*

[27] Keehan, Sean P. "National Health Expenditure Projections, 2022–31: Growth To Stabilize Once The COVID-19 Public Health Emergency Ends." Health Affairs, vol. 42, no. 7, July 2023, https://doi.org/10.1377/hlthaff.

HIP/Emblem	17.0%	1.5%
Healthfirst	14.0%	0.5%
Independent Health	13.9%	2.0%
Fidelis	13.2%	0.5%
United	11.9%	1.5%
MetroPlus	11.3%	0.5%
CDPHP	10.8%	2.0%
Excellus	10.7%	1.5%
Oscar	10.5%	0.9%
HealthPlus	9.1%	2.0%
Highmark	3.1%	1.0%
Average	**11.5%**	**1.3%**

Profit and surplus requests range from 0.5 to 2 percent. The Department capped profit and surplus at 0.5 percent for the 2023 rates. It should do the same for 2024.

H. **Complaint and quality data**

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.

However, the Guide does not include complaint and quality data for all plans available through the individual market. The Department could easily gather this data from its sister agency, the New York State Department of Health, or its own External Appeals database, located on the Department's website. The Department should revamp its Consumer Guide to include all individual market carriers – whose customers would benefit the most from its contents during the course of their enrollment decisions.

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.

II. Emblem/HIP

Emblem/HIP is a non-profit HMO health plan with 7,147 members in 2023. This is a 39.4 percent decline from 2022, when it had 11,790 members. Emblem has lost members every year since 2018. In 2023, it charged the second highest premiums in the individual market at $897 per-member, per-month. Emblem/HIP projects receiving a 13 percent subsidy from the federal risk adjustment program, which means its risk pool is less healthy than the overall individual market and that it will receive a payment to make up for the resulting higher claims. Its individual market plans serve the Albany, Long Island, Mid-Hudson, New York City and Utica/Watertown regions.

Emblem is requesting a 52.7 percent average rate increase for 2024, the most of any carrier. In 2023, Emblem also sought the highest average rate increase at 34.6 percent, which the Department reduced to 9.0 percent. If its 52.7 percent increase were approved, the average rate for Emblem plans would make it the highest priced carrier at $1,370 a month before subsidies. The Department should consider that Emblem has a significantly smaller network than United, the current most expensive plan. To grant another large rate increase would further discourage members from continuing to purchase Emblem's plans.

The Department should consider several areas in which Emblem could reduce its request, including high medical trend assumptions, inflated administrative costs and profits; and a low MLR goal for 2024.

A. **Emblem's estimated 14.2 percent medical trend is higher than every other carrier and almost twice as high as the average.**

Emblem seeks a 14.2 percent medical trend, nearly double the average medical trend projected by the individual market carriers for 2023. This is the second year in a row that Emblem has sought a trend much higher than the other carriers.

In its actuarial memorandum, Emblem cites inflation, medical unit cost, and new expensive prescription drugs. However, no specific new technologies or medications are described, making it impossible for the public to assess this claim. Moreover, there is no explanation for why any of these factors are unique to Emblem as compared with its peers. Other carriers, like Excellus, include a trend chart in their actuarial memo that includes projected medical and drug trends broken down by unit cost and utilization. None of the information provided by the other carriers suggests that claim costs will increase at a double-digit rate.

Absent any evidence to support Emblem's uniquely inflated trend projections, the Department should reduce this adjustment to 7.6 percent, the average across carriers and consistent with national projections for 2024.

B. **Emblem is requesting the highest expense ratio of 17 percent and a high profit ratio of 1.5 percent.**

At 17 percent, Emblem seeks approval for the highest expense ratio of all carriers in the Marketplace – well above the 12 percent average request. It is also much higher than Emblem's expense ratio for the 2023 plan year, in which it sought and was approved at 13.2 percent. The Department should reduce Emblem's expense ratio adjustment to 12 percent, the market average.

Similarly, Emblem asks for a profit of 1.5 percent. The Department should reduce this surplus request to 0.5% as it has for all carriers in past years.

C. **Emblem's 82.1 percent MLR goal is too low for the size of the requested rate increase.**

Emblem seeks a 2023 MLR of 82.1 percent, almost precisely the minimum 82 percent required under New York State law. It projects an MLR of 104.8 percent in 2023 and its MLR exceeded 100 percent in 2022 (at 104.6 percent). However, its average MLR for 2020, 2021, and 2022 was 94.1 percent.

Given how expensive Emblem's plans already are and how large its requested increase is, the Department should require it to set a higher MLR goal for 2024 to avoid rate increases that will drive even more of its members away.

D. **Emblem's claim that the end of the Public Health Emergency (PHE) will have no impact should be rejected.**

Emblem's application does not incorporate a downward adjustment for the migration of consumers back to its Qualified Health Plans from its Medicaid/Essential Plan products in the wake of the end of the PHE. The Department should impose a downward adjustment for the end of the PHE.

E. **Emblem's 2.9 percent upward adjustment for the 1332 Waiver should be reduced to no more than 2.2 percent consistent with New York State's public filings with the federal government.**

Emblem seeks a full 2.9 percent rate adjustment for the migration of its members between 200 and 250 percent of federal poverty level to the Essential Plan should the Waiver be granted. The Department should award no premium adjustment based on speculative assumptions about the impact of the 1332 Waiver – which has yet to be approved.

In any event, if it does approve an upward adjustment, it should not be greater than those publicly disclosed by the State in its filings with the federal government – 2.2 percent.

F. **Emblem's -0.84 percent downward adjustment for Covid-19 utilization should be granted.**

Emblem's .84 percent downward adjustment in recognition of the reduced morbidity and utilization related to Covid-19 care and treatment is reasonable and should be granted.

G. **Emblem's quality and complaint data**

The Department should carefully consider Emblem's complaint and quality performance before approving its extreme rate increase request. According to the Department's Consumer Guide, HIP HMO (dba Emblem) ranks worst among HMOs for handling consumer and prompt pay complaints.[28] It has a better than average reversal rate on External Reviews (42 percent).[29]

Emblem performs very poorly on many access to care indicators, including pivotal measures such as: getting needed care, getting care quickly and members seen by a provider.[30] No other plan performs so poorly on such a fundamental performance measure. Likewise, Emblem performs poorly on many more quality of care measures than its peers, including: childhood immunization; child and adolescent well child visits, all three child and adolescent nutrition measures; adult control of blood pressure; flu shots for adults; breast cancer screening; postpartum care; antidepressant medication management; follow up mental illness visit in an emergency room and hospitalization; and several diabetes measures.[31]

The Department should consider these factors carefully before approving Emblem's extraordinarily high rate request.

H. **Enrollees' concerns should be honored.**

Last, but not least, we urge the Department to consider the voices of Emblem's enrollees, who so eloquently have voiced their objection to its proposed rate increase.

- "I am writing to you to state that I hope you clearly and unequivocally deny this request and to reprimand them for subjecting their current and potentially future clients to such an exorbitant increase. I purchase my healthcare through the NYS Healthcare exchange. It has never been easy or affordable. I have gone without food and am in constant switch up mode to determine which bills I can let wait until I have sufficient funds to pay them. Normally that means ConEd or DEP waits. Leaks in my apartment wait. Providing my child what is needed at college waits. What does not wait EVER is the monthly premium. I currently pay Emblem $1358.84 per month and I do it so that my health needs (which are plentiful) are secure should I require care… I spend about 7 hours a week on the phone dealing with aspects of my insurance and healthcare claims… This request, if granted at any number will force me to exit the marketplace and leave me without any healthcare coverage at a time when I am most vulnerable… My income will not increase

[28] https://www.dfs.ny.gov/system/files/documents/2022/08/ny_consumer_guide_health_insurers_2022.pdf (at 6, 7).
[29] Id. at 21.
[30] Id. at 31.
[31] Id. at 34, 35, 39, 42, 48, 49, 57.

to the point that there is any affordability to this request and where I now switch up to see which bills can wait, I am fairly certain I will be without any healthcare in 2024 because for once I have to make a hard decision to pay rent, eat, provide for my child and keep the utilities on. Please deny them this request. Tell them to wait. Let Emblem and all the other insurers know that service and the care and concern of their clients must sometimes over ride their need to make outlandish requests such as what is being proposed."

Thank you for your consideration of our concerns.

Very truly yours,

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