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 25, 2025

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

RE: Requested Rate Changes – CDPHP - CAPD-134513425

Dear Superintendent Harris, Assistant Deputy McKenney, 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 2026 rate requests submitted by New York's individual market carriers to the Department of Financial Services (the "Department"). 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 CDPHP's request.

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

Governor Hochul has identified the state's affordability crisis to be her top priority for 2025, and this year's rate review process offers the Department an important opportunity to help address this crisis.[1] **On average, the carriers are seeking a 17 percent rate increase or a weighted average rate increase of 13.1 percent, which is more than five times the rate of inflation**. This request follows two years of large weighted average rate increases of 11.9 percent and 13.5 percent for 2025 and 2024, respectively (see Table 2 below). Health insurance premiums and out-of-pocket health care costs comprise a major part of most New Yorkers' budgets, with 66 percent of New Yorkers reporting delaying or doing without health care due to

[1] Governor Kathy Hochul, "A Note from Governor Kathy Hochul," https://www.governor.ny.gov/programs/making-new-york-state-more-affordable.

costs in the past year.[2] Consumers with job-based coverage have employers, brokers, and agents who can negotiate the best premiums, scope, and coverage for their employees. By contrast, consumers in the individual market have no bargaining power over affordable premiums and out-of-pocket costs and are dependent upon the Department to safeguard health insurance affordability through the annual rate review process.

This general comment section describes the following conditions that are likely to influence the rates for the 2026 coverage year: (A) New York's individual market recent request trends and the requests of peer states; (B) medical loss ratios; (C) annual claim trend and the impact of GLP-1 drugs; (D) administrative costs and profit; (E) adjustments for State mandates; (F) migration from the individual market due to federal threats; (G) the degrading quality of carriers' rate request documentation; (H) complaint and quality data; and (I) affirmative policies the Department can take to control premium increases.

A. New York's individual market recent request trends and the requests of peer states

In 2026, New York's individual market carriers seek a weighted average of 13.1 percent premium increase (Table 1). New York is a large state with 12 individual market 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.

The rate request applications range from Emblem's proposed premium increase of 0.9 percent to IHBC's proposed increase of 38.4 percent. Over half of consumers were insulated from premium increases because they received premium subsidies through the temporary enhancements to the Affordable Care Act; however, these subsidies are set to expire at the end of 2025.[3] Nationally, the average premium for a benchmark plan in 2025 is around $500. In New York, the average premium for a benchmark plan is $790, over 150 percent higher, making it the fifth most expensive state for marketplace insurance in the country.[4] If approved, premiums would increase by almost $1,300 per person per year.

Table 1. 2025 and 2026 Individual Market Rate Requests

Plan	*2025 Market Share (Members)*	*2025 Approved Rate Increase*	*2026 Proposed Rate Increase*	*2026 Monthly average premium if approved (difference from 2025)*
IHBC	3.1% (7,300)	24.4%	38.4%	$1,033 (+$287)
United	2.5% (6,000)	0.0%	36.6%	$1,625 (+$436)

[2] "New York State Survey Respondents Struggle to Afford High Health Care Costs," Altarum Health Care Value Hub & the Community Service Society of New York, March 2025, https://www.cssny.org/publications/entry/new-york-state-survey-respondents-struggle-to-afford-high-health-care-costs.

[3] The American Rescue Plan and the Inflation Reduction Act enhanced these subsidies to be both more generous and extend to more people. *2024 Marketplace Open Enrollment Period Public Use Files – 2024 OEP State-Level Public Use File,* Centers for Medicare & Medicaid Services, March 22, 2024, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

[4] *Average Marketplace Premiums by Metal Tier, 2018-2025*, KFF, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Excellus	8.8% (21,000)	18.3%	24.8%	$998 (+$198)
Highmark	1.3% (3,200)	26.5%	23.9%	$1,096 (+$211)
Oscar	3.7% (8,900)	19.4%	17.0%	$1,134 (+$165)
Healthfirst	17.9% (43,000)	12.7%	14.3%	$919 (+$115)
CDPHP	1.3% (3,100)	13.7%	13.7%	$1,017 (+$122)
Anthem	10.3% (24,700)	12.7%	10.3%	$983 (+$92)
MetroPlus	2.4% (5,700)	23.6%	10.1%	$1,017 (+$93)
Fidelis	39.8% (95,600)	5.9%	8.1%	$756 (+$56)
MVP	8.0% (19,100)	17.9%	8.0%	$881 (+65)
Emblem	1.0% (2,400)	35.6%	0.9%	$1,571 (+$14)
Total/ Weighted Average	**240,100**	**17.6%**	**17.2%**	**$906 (+$108)**

New York's individual market carriers have a history of seeking larger premium increases than are ultimately approved (Table 2). Historically, the Department has scrutinized the carriers' outsized rate requests, often paring them back by roughly 50 percent or more (e.g., plan years 2023, 2022, 2021, 2019) (Table 2).

Table 2. New York Individual Market Requested vs. Approved Premium Increase			
Plan Year	*Requested Change*	*Approved Change*	*Percent Change*
2025	15.5%	11.9%	-23.2%
2024	20.1%	13.7%	-31.8%
2023	17.9%	9.6%	-46.4%
2022	10.3%	3.2%	-68.9%
2021	11.4%	1.5%	-86.8%
2020	8.8%	6.7%	-23.9%
2019	23.7%	9.0%	-62.0%
2018	17.7%	13.9%	-21.5%
2017	19.3%	16.6%	-14.0%

New York carriers' approved rate changes typically exceed those of other states, making it a national outlier (Table 3). CMS has approved a 5.1 percent increase for Medicare Advantage plans for 2026.[5]

Table 3. Rate Adjustments in Comparable State Individual Markets					
	Approved Rate Change 2024	*Approved Rate Change 2025*	*Average Request 2026*	*Individual Market Size*	*Number of Carriers*

[5] *2026 Medicare Advantage and Part D Rate Announcement,* Centers for Medicare & Medicaid Services, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement.

Washington[6]	8.2%	8.8%	21.2%	305,600	15
New York	15.1%	12.5%	17.2%	240,100	12
Maryland[7]	6.6%	4.7%	17.1%	291,600	7
Massachusetts[8]*	7.6%	2.8%	13.4%	721,400	8
Oregon[9]	6.7%	6.3%	9.7%	162,400	6
Medicare Advantage[10]	2.1%	3.7%	5.1%	n/a	n/a

For the 2026 plan year, HCFANY urges the Department to consider substantially reducing the carriers' requests in light of the past two years' relatively large rate increases and the State's current affordability crisis.

B. Medical loss ratios

The carriers' medical loss ratios (MLRs) indicate the proportion of revenue spent on health care for members versus administrative costs and profit/surplus. During the height of the COVID-19 pandemic, New York plans experienced high net incomes in 2020, followed by lower net incomes from 2021 to 2023. By 2024, the carriers' filings indicate that their MLRs have stabilized at 92.2 percent, and they project an average MLR of 87.6 percent for the 2025 plan year (Table 4). Some carriers seek unnecessarily low MLRs. For example, IHBC requests a 38 percent rate increase to drive its MLR from 98 percent in 2024 to 82 percent in 2026. Oscar has requested a 79.4 percent MLR for 2026, a value lower than the MLR required by the Affordable Care Act and State law.

Table 4. Medical Loss Ratios in New York's Individual Market, 2022-2026

Plan	*2022*	*2023*	*2024*	*Projected 2025*	*Requested 2026*
Healthfirst	87.1%	87.1%	87.6%	89.1%	90.4%
Highmark	117.4%	120.8%	133.3%	102.3%	90.0%
Anthem	83.1%	94.2%	86.6%	85.0%	89.7%
Excellus	99.6%	96.8%	101.2%	93.7%	88.9%
United	97.8%	87.5%	95.0%	94.3%	88.7%

[6] *Insurers seek 21.2% average rate change for 2026 individual health insurance market,* Office of the Insurance Commissioner Washington State, May 27, 2025, https://www.insurance.wa.gov/about-us/news/2025/insurers-seek-212-average-rate-change-2026-individual-health-insurance-market

[7] *Insurance Administration Rate Review,* Maryland.gov, June 2025, http://www.healthrates.mdinsurance.state.md.us/.

[8] *Merged Market Summary for Proposed Rates Effective for 2026,* Massachusetts Division of Insurance, May 29, 2025, https://www.mass.gov/info-details/2026-health-insurance-rates#merged-market-summary-for-proposed-rates-effective-for-2026. **Rate Request Averages, People in Market, and Carrier numbers are reflective of Massachusetts merged data, which combines individual and small group markets.*

[9] *Oregonians continue to have at least five health insurance companies to choose from in every Oregon county as companies file 2026 health insurance rate requests for individual and small group markets*, Oregon.gov Division of Financial Regulation, June 2, 2025, https://dfr.oregon.gov/news/news2025/Pages/20250602-2026-health-insurance-rate-requests.aspx

[10] *2026 Medicare Advantage and Part D Rate Announcement,* Centers for Medicare & Medicaid Services, April 7, 2025, https://www.cms.gov/newsroom/fact-sheets/2026-medicare-advantage-and-part-d-rate-announcement.

CDPHP	116.1%	99.6%	92.1%	88.0%	86.3%
MVP	92.4%	94.1%	88.4%	87.1%	86.1%
MetroPlus	102.2%	95.8%	87.2%	88.4%	84.7%
Fidelis	89.4%	91.1%	77.0%	72.4%	82.9%
Emblem	104.6%	116.2%	71.7%	81.7%	82.6%
IHBC	116.2%	113.3%	98.3%	90.5%	82.0%
Oscar	90.3%	90.7%	88.0%	78.5%	79.4%
Average[11]	**99.7%**	**98.9%**	**92.2%**	**87.6%**	**86.0%**

The Department should evaluate the carriers' projected MLRs for the 2026 plan year and return to its historic practice of protecting consumers by curbing the carriers' proposed requests.

C. Annual claim trend and the impact of GLP-1 drugs

The annual claim trend is the portion of the rate request based on changes in prices and utilization. Insurance spreads risk and aggregates enrollees' bargaining power to leverage price negotiations with providers, drug makers, and medical equipment manufacturers.

New York's carriers submitted inconsistent annual claim trend estimates that indicate that many carriers have not controlled health care costs effectively. There is significant variation in the 2026 trend estimates, from 7.8 percent to 11.2 percent, or a 9.1 percent average trend rate. (Table 5). The Department should consider two factors as it reviews the carriers' proposed trend adjustments: (1) accuracy of the carriers' trend projections in light of 2024 experience data; (2) the legitimacy of the purported impact of GLP-1s on trend; and (3) New York's trend compared to national benchmarks.

Table 5. Annual Claim Trend and GLP-1 Drug Adjustment by Carrier

Plan	*GLP-1 Adjustment*	*NYS DFS Approved Claim Trend for 2025*	*Estimated Annual Claim Trend for 2026*
MetroPlus	0.0%	8.0%	11.2%
IHBC	1.1%	8.0%	10.8%
Emblem	1.0%	8.0%	10.7%
Healthfirst	3.6%	7.0%	10.0%[12]
CDPHP	1.4%	8.0%	9.6%
Anthem	3.2%	8.0%	9.4%
Excellus	1.8%	8.0%	9.3%
United	1.1%	8.0%	9.1%
Highmark	1.0%	8.0%	9.0%
MVP	1.1%	7.7%	8.7%
Fidelis	0.5%	7.9%	8.5%

[11] Unweighted average.
[12] Healthfirst 2026 Rate Application, Actuarial Memorandum, page 4. See Healthfirst carrier-specific letter for details on inconsistencies within its projected annual claim trend.

Oscar	0.0%	5.9%	7.8%
Weighted Average	**1.5%**	**7.7%**	**9.1%**

First, New York's trend estimates appear to be overly conservative in light of their actual experience. For example, in 2024, the Department approved a weighted average trend of 6.8 percent in response to the carriers' requested 7.02 percent. But a review of the carriers' 2026 applications reveals that they experienced just a 5.1 percent weighted average annual claim trend in 2024, indicating that their requests were inflated by 1.92 percentage points. For 2025, the carriers sought a weighted average of 8 percent annual claim trend, which the department reduced to 7.7 percent. The accuracy of their projections should be assessed carefully considering the actual 2025 trend experience.

Second, the impact of GLP-1s upon the carriers' 2026 trend estimates may be exaggerated. In its 2025-26 rate application instructions, the Department asked carriers to separate the costs associated with covering GLP-1 drugs. It does not appear that the Department's instructions directed the carriers to exclude GLP-1 from their annual claim trend adjustments, risking a double count. Only two carriers mentioned that the pharmaceutical component of their annual claim trend data removed GLP-1 claims.[13]

The landscape of GLP-1 utilization is rapidly changing, and many carriers do not provide coverage for the drug. For example, one national study found that 60.5 percent of GLP-1 claims were rejected in 2024.[14] Another KFF survey found that only a quarter of insured adults who had taken GLP-1s had insurance that fully covered the cost.[15] Still another analysis of over 10 years of weight management-related GLP-1 claims found that less than half of those who were prescribed the drug continued to take it past the 12-week mark.[16] Finally, there has also been a recent rise in Direct To Consumer (DTC) routes of GLP-1 provision. This market is separate from and often more affordable than the list and net prices through the commercial marketplace. GLP-1s can cost insured individuals around $9,000 out-of-pocket annually. By contrast, DTC costs are closer to an average of $6,000.[17] All of these studies call into question whether New York's individual market carriers are covering GLP-1s significantly.

Other states appear to be moving cautiously with respect to GLP-1 as part of their annual claim trend adjustments. For example, only one of 14 carriers in Washington state included GLP-

[13] In their actuarial memos, Excellus and Emblem specify the removal of GLP-1 claims data from their pharmaceutical trend calculations.
[14] Son, Max, Alison Edwards and Brianne Burns. *Contributor: Yearly Trends in Coverage Rates for GLP-1 RAs in Weight Loss.* AJMC. May 29, 2025. https://www.ajmc.com/view/contributor-yearly-trends-in-coverage-rates-for-glp-1-ras-in-weight-loss.
[15] *KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs*, Kaiser Family Foundation, May 10, 2024, https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/
[16] *Real-World Trends in GLP-1 Treatment Persistence and Prescribing for Weight Management,* Blue Health Intelligence, May 2024, https://www.bcbs.com/media/pdf/BHI_Issue_Brief_GLP1_Trends.pdf
[17] *Affordable Access to GLP-1 Obesity Medications: Strategies to Guide Market Action and Policy Solutions*, Institute for Clinical and Economic Review, April 9, 2025, https://icer.org/wp-content/uploads/2025/04/Affordable-Access-to-GLP-1-Obesity-Medications-_-ICER-White-Paper-_-04.09.2025.pdf

1s as a component of its pharmaceutical trend in its 2026 application.[18] In Massachusetts, half the carriers' 2026 rate applications specify that they do not cover GLP-1s for obesity.[19]

In short, the Department should require the carriers to provide evidence of actual coverage of this drug, backed up by claims experience, before considering any significant GLP-1-related trend adjustment for the 2026 plan year.

Third, the Department should consider questioning why New York's trend requests deviate significantly from national norms, and the trend sought by carriers in other states. At the national level, health care cost inflation is considerably lower than trends proposed by New York's carriers (Table 6). CMS's National Health Expenditure Panel projects 3.8 percent private insurance spending growth for 2025 and 2026. This is significantly lower than the CMS growth estimate of 8.1 percent in 2024, indicating that trend in health expenditures is expected to decelerate by four percentage points for 2026.[20]

Table 6. National Health Care Trend Projection	
Source	*Composite Health Care Trend Projection*
Segal[21]	8.0%
PWC[22]	7.5%
Milliman[23]	6.7%
CMS[24]	3.8%
Average	**6.0%**

The Department has a critical role in controlling health care cost inflation. It is commendable that in 2025, it capped the trend at 8 percent. However, with inflation stabilizing and for the reasons described above, the Department should be more aggressive in capping the trend at 6 percent for the 2026 plan year. In addition, HCFANY recommends that the Department disallow any adjustment for GLP-1s absent proof from the carriers that they are indeed covering them and have evidence-backed claims experience.

[18] *Health Insurance Rate Increases*, Washington State Office of the Insurance Commissioner, June 2025, https://fortress.wa.gov/oic/consumertoolkitrt/Search.aspx
[19] *2026 Health Insurance Rates*, Commonwealth of Massachusetts, June 2026, https://www.mass.gov/info-details/2026-health-insurance-rates
[20] *National Health Expenditure Projections 2023-2032*, CMS, https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf.
[21] Medical Plan Cost Trend is projected to increase at median levels of 8 percent for 2025. *What Are the Projected Health Plan Cost Trends for 2025?,* Segal, https://www.segalco.com/consulting-insights/2024-health-plan-cost-trend-survey.
[22] *Medical Cost Trend: Behind the Numbers 2025*, PWC, https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.
[23] The increase in health care costs for the average person is 6.7 percent. *2025 Milliman Medical Index* https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/2025-Milliman-Medical-Index.pdf.
[24] 2026 projection. *National Health Expenditure Projections 2023-2032*, CMS, https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf.

D. Administrative costs and profit

The carriers project excessive variations in administrative costs and profits. On average, the carriers seek to spend 12 percent of their rates on administrative costs and over 2 percent of their rates on profit (Table 7).

New York has a robust individual market, with many carriers, and the state is in a strong position to improve affordability for consumers by capping administrative costs. For the second year in a row, Emblem seeks the largest administrative costs adjustment (15.7 percent). Anthem expects the lowest, at 8.1 percent. The Department should consider setting an expense ratio ceiling at or below 10 percent, in recognition of the State's health care affordability crisis.

Table 7. Administrative Costs vs Profit

Plan	*Projected Administrative Costs*	*Requested Profit/Surplus*
Emblem	15.7%	2.0%
Oscar	15.7%	3.9%
IHBC	15.0%	3.0%
Fidelis	13.8%	2.0%
Healthfirst	12.7%	1.5%
MetroPlus	12.7%	1.5%
MVP	11.9%	2.0%
CDPHP	11.5%	2.0%
Excellus	9.6%	1.5%
United	9.0%	5.0%
Highmark	8.2%	1.5%
Anthem	8.1%	2.0%
Average	**12.0%**	**2.3%**

Likewise, the carriers project significant variations in their profit and surplus requests—ranging from 1.5 to 5 percent. The Department capped profit and surplus at 0.5 percent for the 2023 rates, 0.87 percent for 2024, and 1 percent for 2025.

In light of the State's affordability crisis and four years of unprecedented rate increases, the Department should consider protecting consumers and return to its prior practice of capping profit and surplus at 0.5 percent for the 2026 plan year.

E. Adjustments for State mandates

The Department's instructions for the 2025-26 rate applications include lines for several State mandates, including: (i) cost-sharing subsidies for chronic conditions; and (ii) eliminating cost-sharing for insulin. Insurers will be reimbursed for these initiatives from the 1332 Waiver pass-through funds or via the Insurer Reimbursement Implementation Plan (IRIP); therefore, they will not be factored into premiums.

i. Cost-sharing subsidies for chronic conditions

The Department's instructions include a line for the impact of cost-sharing subsidies for people with incomes below 350 percent FPL who are diabetic and/or pregnant/postpartum. There is considerable variation amongst the carriers (0 to 2.8 percent) for this line. No carrier offered concrete claims-based evidence for its utilization projections. The average adjustment, weighted by market share, is 0.01 percent (Table 8).

Table 8. Cost Sharing Subsidies for Chronic Conditions	
Plan	*Cost Sharing Subsidies for Chronic Conditions*
MetroPlus	2.80%[25]
United	2.05%
Excellus	1.15%
Healthfirst	1.00%
Anthem	0.95%
Highmark	0.90%
Emblem	0.49%
MVP	0.42%
IHBC	0.15%
CDPHP	0.0%
Fidelis	0.0%
Oscar	-
Weighted Average	**0.01%**

The Department should consider standardizing the adjustment for this measure at the weighted average of 0.01 percent to avoid reliance on unsupported projections for future utilization.

ii. Eliminating cost-sharing for insulin improves health outcomes and leads to carrier savings

In the 2025-26 rate applications, half of the carriers requested adjustments for the elimination of cost-sharing for insulin. Across the individual market, there was a weighted average adjustment of less than a tenth of one percent (0.08 percent), demonstrating the minor impact of eliminating cost-sharing for insulin on the individual market (Table 9).

Table 9. Requested adjustments for the elimination of cost sharing for insulin	
Plan	*Requested adjustment for elimination of cost sharing for insulin*

[25] There is a discrepancy between the Metroplus Actuarial Memorandum and its Exhibit 18 Supplement. The Actuarial Memorandum indicates that the Cost Sharing Subsidies for Chronic Conditions should be adjusted by a factor of 2.8%; however, its Exhibit 18 Supplement has a 6.6% adjustment in the cell for this measure.

Excellus	0.70%
United	0.60%
Highmark	0.15%
Healthfirst	0.10%
Emblem	0.10%
IHBC	0.06%
Anthem	No Adjustment
CDPHP	No Adjustment
Fidelis	No Adjustment
Metroplus	No Adjustment
MVP	No Adjustment
Oscar	No Adjustment
Weighted Average[26]	**0.08%**

Medical literature indicates that the elimination of cost-sharing for chronic conditions significantly increases medication adherence, improves health outcomes, and generates carrier savings.[27] The reduction in expensive emergency care that results from non-adherence due to high medication cost offsets the increased costs for carrier when cost sharing for medications to treat chronic conditions is eliminated.

For example, a Blue Cross Blue Shield of Louisiana case study in 2021 studied the impact of eliminating copays for prescription medications that treat chronic conditions, including insulin. Medication adherence increased for most enrollees, especially those with the lowest incomes. It also *saves* health plans money: the follow-up evaluation of the program found a 10 percent decrease in medical spending, leading to an average net savings of $63 per member per month.[28]

In addition, cost sharing elimination contributes to improving health equity as low-income communities, communities of color, and other marginalized communities have worse medication adherence due to cost, so these communities stand to benefit further from the elimination of cost sharing.[29]

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[26] Includes carriers with no adjustment in the weighted average in order to determine premium impact on the market as a whole. The straight average of just the carriers with a non-zero adjustment is below a third of a percent (0.29 percent).

[27] Fusco et al., "Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review," *J Manag Care Spec Pharm*. January 2023, 4-16. doi: 10.18553/jmcp.2022.21270.

[28] Cong et al., "Association of co-pay elimination with medication adherence and total cost*," AJMC,* June 2021, 249-254. doi: 10.37765/ajmc.2021.88664.

[29] Essien UR, Lusk JB, Dusetzina SB. Cost-Sharing Reform for Chronic Disease Treatments as a Strategy to Improve Health Care Equity and Value in the US. JAMA Health Forum. 2022;3(12):e224804. doi:10.1001/jamahealthforum.2022.4804; States Curb Racial Inequities in Rx Drug Affordability with Targeted Legislation, National Academy for State Health Policy. October 2020. https://nashp.org/states-curb-racial-inequities-in-rx-drug-affordability-with-targeted-legislation/.

Accordingly, the Department should consider a **downward** rate adjustment for the elimination of cost sharing for insulin as the carriers will experience net savings from this policy.

F. Migration from the individual market due to federal threats

New York's individual market currently covers approximately 240,000 people, down from 307,000 people last year (Table 10). Federal threats to funding and coverage will disproportionately and adversely impact New York's individual market in three ways: (1) the expiration of American Rescue Plan subsidies; (2) the CMS 2025 Marketplace Integrity and Affordability Proposed Rule; and (3) the loss of lawfully permanent residents from the individual market. New Yorkers make up over 10 percent (1.5 million) of the 16 million people projected to lose coverage due to these federal measures.

Table 10. Enrollment in New York's Individual Market

Plan Year	*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	237,314	-9.3%
2024	307,021	26.8%
2025	240,065	-21.8%

In 2021, Congress expanded health insurance coverage affordability by creating Enhanced Premium Tax Credits (EPTCs) to help individuals and families purchase health insurance on the marketplace under the American Rescue Plan. These EPTCs are set to expire at the end of 2025. The Department estimates that this cut—if it materializes—would result in 50,000 enrollees leaving the individual market.[30] The CBO anticipates that healthier-than-average people will exit the marketplace and that insurers will raise premiums by 4.3 percent in 2026.[31] Several carriers cite this national CBO estimate.[32] However, there is a possibility that the

[30] Holahan, D, & Sekhar, S. (2025, February). New York Delegation Briefing: Enhanced Premium Tax Credits and Essential Plan Waiver | NY State of Health. https://hcfany.org/wpcontent/uploads/2025/03/NYSOH-Congressional-Briefing-Feb-2025.pdf. *Comments on 90 FR 12942, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*. NY State of Health and NYS Department of Financial Services, March 19, 2025. https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Comment%20Marketplace%20Integrity.pdf.

[31] Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. Congressional Budget Office. June 4, 2025. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf. Congressional Budget Office. The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums. December 5, 2024. https://www.cbo.gov/publication/59230.

[32] Emblem and Healthfirst actuarial memoranda.

tax credits will be extended at the eleventh hours or that the State will adopt a State premium assistance program to offset their impact.

Accordingly, the Department should not permit any adjustment related to the expiration of EPTCs for 2026 due to the absence of data that would allow the Department and consumer to understand the realized impact on the individual market. If the Department finds that it is necessary to make an upward adjustment for the 2026 plan year, it should set a ceiling of 3.6 percent, based on the average adjustment for the expiration of EPTCs among the individual market carriers.

Table 11. Expiration of Enhanced Premium Tax Credits	
Plan	*Expiration of American Rescue Plan Enhanced Premium Tax Credits*
MVP	6.9%
United	6.2%
Fidelis	4.6%
CDPHP	4.3%
Emblem	4.3%
Healthfirst	4.3%
Anthem	3.1%
MetroPlus	2.5%
Highmark	2.5%
IHBC	2.3%
Excellus	1.6%
Oscar	0.0%
Average	**3.6%**

Second, CMS proposed a Marketplace Integrity and Affordability rule in March 2025 that is projected to cause an estimated 900,000 Americans to lose coverage.[33] The rule includes a shortened annual open enrollment period; restrictions on special enrollment periods; termination of coverage for DACA recipients; ability for insurers to condition new coverage on repayment of outstanding premiums; and mandating de minimis premium payments for individuals eligible for free coverage. According to a joint letter submitted by the Department and NYSOH, the proposed rule would raise premium costs by 4.5 percent if implemented and result in 6,000 fewer enrollees in QHPs.[34]

[33] Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. Congressional Budget Office. June 4, 2025. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[34] *Comments on 90 FR 12942, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*. NY State of Health and NYS Department of Financial Services, March 19, 2025. https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Comment%20Marketplace%20Integrity.pdf.

Finally, Congress seeks to terminate eligibility for premium assistance for most lawfully present immigrants, leading to 10.9 million people losing coverage by 2034.[35] At the time of writing this correspondence, it is unclear whether this will actually come to pass, and if it does, how many lawfully present immigrants are participating in the individual market. If it should transpire, the loss of this population will harm the individual market risk pool since they tend to be younger and healthier than other US Citizen counterparts.

The Department should continue to monitor the proposed actions of the federal government on the individual market and adjust premiums accordingly following implementation to ensure adjustments are accurate.

G. The degrading quality of carriers' rate request documentation

To have a meaningful public rate review process, the Department and the public should be able to review clear and comparable filings. Despite the Department's clear and comprehensive instructions, some carriers continue to deliver inconsistent information between their actuarial memoranda and their exhibits and otherwise disregard of the Department's instructions. For example, Anthem and MVP's actuarial memoranda provide very brief and unspecific descriptions of annual claim trend with no numbers, sources, or justifications. Healthfirst has inconsistent information between its actuarial memoranda and exhibits for annual claim trend. And Oscar's actuarial memorandum is missing Exhibit 18: Supplemental Exhibits (a section required by the Department).

Obtaining comprehensible actuarial memoranda is attainable. For example, Healthfirst provided an otherwise comprehensive and detailed actuarial memorandum. In addition to listing the premium adjustments the carrier seeks, it also provides its sources, calculations, and justification for each adjustment. Fidelis, the carrier with the longest actuarial memorandum, includes a detailed outline of its rate projection process and many supporting tables of calculations. Excellus ends its actuarial memorandum with a page confirming its contents conform to the DFS 2026 filing instructions.

Starting in 2027, the Department should consider rejecting or reducing rate increases for carriers whose memoranda include excessive redactions or fail to follow the Department's template.

H. Complaint and quality data

HCFANY also urges the Department to incorporate its complaint and quality information into the rate review process. To this end, it would be helpful for consumers if the Department revised its Consumer Guide to include complaint and quality data for *all plans* available in the individual market. Currently, 80 percent of the individual market are enrolled in plans that are omitted from the guide. Individual market consumers with Fidelis (40%), Healthfirst (18%), Anthem (10%) and MetroPlus (2%) coverage are unable to review complaint and quality data for

[35] Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. Congressional Budget Office. June 4, 2025. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

their plans (Table 12). Further, the guide excludes quality and access to care data for EPO products, impacting a third of the individual market carriers and 16.9 percent of consumers on the individual market.[36] The Department could acquire information about these products from its External Appeals database and from its sister agency, the New York State Department of Health, to ensure that the Consumer Guide serves consumers enrolled in the individual market.

Table 12. Exclusion of Carriers from Consumer Guide			
Plan	*2025 Market Share (Members)*	*Section: Complaints, Appeals, and Grievances data*	*Section: "Quality of Care and Service for Health Insurance Companies"*
Fidelis	39.8% (95,600)	**Excluded**	**Excluded**
Healthfirst	17.9% (43,000)	**Excluded**	**Excluded**
Anthem	10.3% (24,700)	**Excluded**	**Excluded**
Excellus	8.8% (21,000)	Included	Included
MVP	8.0% (19,100)	Included	Included
Oscar	3.7% (8,900)	Included	**Excluded**
IHBC	3.1% (7,300)	Included	**Excluded**
United	2.5% (6,000)	Included	**Excluded**
MetroPlus	2.4% (5,700)	**Excluded**	**Excluded**
Highmark	1.3% (3,200)	Included	Included
CDPHP	1.3% (3,100)	Included	Included
Emblem	1.0% (2,400)	Included	Included
Market Share	**---**	**70.4%**	**79.7%**

Once it reflects the entire individual market, HCFANY urges the Department to use the important data contained in the guide to assess the carriers' rate applications. When plans have high reversal rates, it sometimes means they deny care without any basis and then spend 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 Department should consider integrating these independent, consumer-facing metrics of product value into its prior approval review. When plan members are unable to access care, the company should be asked to improve before authorizing large rate increases.

I. Affirmative policies the Department can embrace to control premium increases

HCFANY urges the Department to work with the Governor to reduce and rebalance New York's health care spending in the 2026-27 Executive Budget or through its own program bills. New York has the second highest overall health care spending per person ($14,000) in the nation. Hospital care is the single biggest contributor (39 percent) to this spending, rising twice

[36] Excellus Health Plan, Highmark, Independent Health Benefits Corporation, and Oscar Insurance Corporation offer EPO plans on the individual market.

as fast as wages and four times as fast as inflation in the past decade.[37] In their 2026 rate applications, several carriers cite skyrocketing hospital costs, stating that hospitals (inpatient and outpatient care) account for the largest share of the health care premium dollar in New York, a percentage that continues to grow.[38] Yet insurers seem unable to use their negotiating power to command lower prices on behalf of their enrollees. Here are some affirmative cost-control measures adopted by other states that New York could pursue.

Adopting an affordability standard with hospital price growth benchmarks. Other states are moving forward to protect enrollees from escalating premiums. The Department should consider advocating for affordability standards through the prior approval process, as done in Rhode Island. Carriers must maintain contracted hospital price increases below inflation plus one percent. In addition, they must ensure that at least half of the average rate increase will go towards quality incentive payments.[39] **A 2025 Health Affairs review found that Rhode Island's affordability standards and hospital price growth target led to a 9 percent reduction in hospital prices, translating into premium reductions of $1,000 per member *per year*.**[40] Rhode Island was also the first state to mandate that commercial insurers increase primary care spending by one percent per year, with the goal of reaching 10 percent of the total cost of care. As a result, primary care spending in Rhode Island grew by 37 percent from 2008 to 2012. During the same period, total medical spending fell 14 percent.[41]

Enacting the Primary Care Investment Act (A1634|A1915A) or establishing primary care spending benchmarks through prior approval. New York's carriers pay an outsized portion of their premiums for expensive hospitalization instead of primary care. New York does not currently require measurement or reporting of the proportion of health care expenditures spent on primary care. Investing in primary care is the only part of the health system proven to lengthen lives and reduce inequities at the population level.[42] It can also reduce strain on hospitals.[43] In New York, 70 percent of emergency department visits are either non-

[37] Centers for Medicare & Medicaid Services. "Health Expenditures by State of Residence," 2022. Accessed September 2024. http:// www.cms.gov/Research-Statistics-Dataand-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ resident-state-estimates.zip.
[38] Anthem HP, CDPHP. Individual Market Rate Application 2025 for 2026, Exhibit 13b: Narrative Summaries.
[39] Butler, Johanna, *Disrupting Hospital Price Increases: Using Growth Caps in Insurance Rate Review*, National Academy for State Health Policy (NASHP), December 2021, https://nashp.org/disrupting-hospital-price-increases-using-growth-caps-in-insurance-rate-review/#:~:text=A%202019%20Health%20Affairs%20review,%2455%20from%202010%20to%202016.
[40] Ryan, Andrew M, et al. Rhode Island's Affordability Standards Led to Hospital Price Reductions and Lower Insurance Premiums. May 2025. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01146.
[41] *Primary Care Spending in Rhode Island*, Office of the Health Insurance Commissioner – State of Rhode Island, January 2014, https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf.
[42] McCauley, Linda, Robert L. Phillips, Marc Meisnere, and Sarah K. Robinson, eds. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, D.C.: National Academies Press, 2021. Page 4. https://doi.org/10.17226/25983.
[43] McCauley, Linda, Robert L. Phillips, Marc Meisnere, and Sarah K. Robinson, eds. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, D.C.: National Academies Press, 2021. Page 4. https://doi.org/10.17226/25983.

emergent or could be treated by a primary care provider, over double the national rate.[44] New York should follow the lead of at least 17 states that have enacted laws or promulgated regulations to increase spending on primary care over time.[45] Rhode Island and Delaware enforce primary care investment benchmarks through prior approval.[46]

Establishing an Independent Office of Health Care Affordability. Other states have taken a variety of approaches to achieve reduced and more efficient health care spending. In California, the legislature established an independent Office of Health Care Affordability (OHCA) to set a benchmark for the growth of health care costs, restrict consolidation, and uphold standards for quality and equity. The OHCA set a statewide health care spending target of 3.5 percent for 2025 in addition to hospital-specific spending targets for hospitals with the highest costs.[47] In Delaware, a hospital cost review board reviews and regulates budgets to control skyrocketing hospital costs. At least nine states have taken steps to develop health care cost growth benchmarks, most of which are informed by an All Payer Database (APD) (Table 13).[48] In 2011, New York was a leader in enacting APD legislation. Fourteen years and $159 million later, New York has no APD, lagging behind dozens of its peer states.[49] The Department should work with Department of Health regulators to support the implementation of this 2011 law and launch a public-facing APD, in addition to making data to inform a cost growth benchmark accessible to regulators.

Table 13. State Health Care Cost Growth Targets

State	*Mechanism*	*Year Established*	*Enforcement Authority*	*Informed by APD*	*Benchmark*[50]
California	Legislation[51]	2022	Yes	Yes	3.0-3.5%[52]

[44] NYS Department of Health. "Hospital Emergency Department (ED) Care in New York State – 2017- 2021 SPARCS data," January 2023. https:// www.health.ny.gov/facilities/public_health_and_ health_planning_council/meetings/2023-02-08/ docs/hospital_ed_care.pdf; Majewski, Phil and Lobick, Dawn. "Appropriate ED Utilization Leading to Better Care Coordination." American Journal of Managed Care. 2022. https://www. ajmc.com/view/appropriate-ed-utilizationleading-to-better-care-coordination

[45] Patient Centered Primary Care Collaborative. "Investing in Primary Care: A State Level Analysis." July 2019. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.

[46] Rhode Island Office of the Health Insurance Commissioner. "Primary Care in Rhode Island: Current Status and Policy Recommendations." December 2023. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-12/Primary%20Care%20in%20Rhode%20Island%20-%20Current%20Status%20and%20Policy%20Recommendations%20December%202023.pdf; State of Delaware. 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance, 1322 Delaware General Assembly Administrative Code Title 18 § (2022).

[47] Office of Health Care Affordability (OHCA) https://hcai.ca.gov/affordability/ohca/

[48] CSS review of APCD databases by state.

[49] D'Ambrosio, Amanda. "New York Fumbles Health Costs Database despite Millions in Investments." Crain's New York Business, November 5, 2024. https://www.crainsnewyork.com/health-pulse/ new-york-fumbles-health-costs-databasedespite-millions-investments.

[50] As of 2023. https://tcf.org/content/report/cost-growth-benchmarks-can-make-health-care-more-affordable-and-equitable/

[51] Legislation to establish the Office of Health Care Affordability. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB184.

[52] The Office of Health Care Affordability set statewide a health care spending target that starts at 3.5% in 2025 and phases down to 3% by 2029. https://hcai.ca.gov/affordability/ohca/slow-spending-growth/.

Connecticut	Executive Order, Legislation[53]	2020	No	Yes	3.9%
Delaware	Executive Order, Legislation[54]	2018	No	Yes	3.1%
Massachusetts	Legislation[55]	2012	Yes	Yes	3.6%
Nevada	Executive Order, Legislation[56]	2021	No	No	2.98%
New Jersey	Executive Order, Voluntary Compact[57]	2021	No	No	3.5%
Oregon	Legislation [58]	2019	Yes	Yes	3.4%
Rhode Island	Executive Order, Voluntary Compact[59]	2019	No	Yes	3.2%
Washington	Legislation[60]	2020	No	Yes	3.2%

[53] Executive Order No. 5 directing the development of annual health care cost growth benchmarks. https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-5.pdf?la=en&hash=D94E97781672A65208C7BED8F46EA316
House Bill 5042 to codify the health care cost growth benchmarks into law. https://www.cga.ct.gov/asp/CGABillStatus/cgabillstatus.asp?selBillType=Bill&bill_num=HB5042

[54] Executive Order 25 to establish state health care spending and quality benchmarks. https://governor.delaware.gov/executive-orders/eo25/
House Bill 442 to codify health care spending and quality benchmarks established through Executive Order 25. https://dhss.delaware.gov/dhss/files/hb442.pdf

[55] Legislation on health care cost containment, which included the establishment of health care cost growth benchmarks. https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224

[56] Executive Order 2021-29 to establish a health care cost growth benchmark. Assembly Bill 348 designating the Patient Protection Commission as the governing body for the state's cost growth benchmark program. https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7886/Text

[57] Executive Order 217 to establish an Interagency Health Care Affordability Working Group to develop proposals for the development and implementation of an annual health care cost growth benchmark and health insurance affordability standard. https://nj.gov/infobank/eo/056murphy/pdf/EO-217.pdf
Executive Order 277 to launch the cost growth benchmark. https://nj.gov/infobank/eo/056murphy/pdf/EO-277.pdf
Voluntary compact: Health Care Affordability, Responsibility, and Transparency Program Blueprint, including language for a stakeholder compact to reduce the rate of health care cost growth in the state. https://nj.gov/governor/news/news/562022/docs/20220331a_Benchmark-Blueprint.pdf

[58] Senate Bill 889 and House Bill 2081 to establish the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority.
https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled
https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled

[59] Executive Order 19-03 to establish a health care cost growth target. [1]
https://files.constantcontact.com/572742fa401/4cea8cdb-7832-4fe2-a790-7ac74b45ddda.pdf
Voluntary Compact to reduce the growth in health care costs and state health care spending. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/cost-trends-project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf

[60] Legislation to establish the Health Care Cost Transparency Board. https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session Laws/House/2457-S2.SL.pdf?q=20210212125253.

II. CDPHP

CDPHP is a non-profit health insurer that offers individual HMO plans in the Albany, Mid-Hudson, Syracuse, and Utica/Watertown regions. CDPHP projects receiving a small payment from the federal risk adjustment program, indicating that its risk pool is slightly less healthy than the overall individual market, and it will receive a payment to make up for the resulting higher claims.

According to its filing, CDPHP has 3,146 members in 2025, a 33 percent decrease in members since 2024 and the second lowest membership in the individual market. It has lost nearly half of its membership (46 percent) since 2019. Despite this, CDPHP remains one of the more expensive upstate plans. Its rates increased by 12.1 percent in 2024 and 13.7 percent in 2025. CDPHP seeks a 13.7 percent average rate increase for 2026, higher than the weighted market-wide average request of 13 percent. If approved, average premiums would be $1,017 per member per month—requiring its members to pay on average $1,467 more annually.

The Department should strongly consider reducing CDPHP's rate adjustment to protect its remaining members. This can be achieved in the following areas: increasing its low MLR goal for 2026; examining its high annual claim trend; and guarding against further administrative expense ratio increases.

A. CDPHP has stabilized its Medical Loss Ratio (MLR) at 88 percent.

CDPHP experienced high MLRs after the COVID-19 pandemic, following trends nationally and among some New York carriers. Its MLR peaked at 116 percent in 2022, and as a result, the Department approved a 16.5 percent rate increase for 2023, the highest among all individual market carriers that year. This successfully brought its MLR down to 99 percent in 2023, 92 percent in 2024, and a projected 88 percent in 2025. CDPHP has requested an MLR of 86.3 percent for 2026, which is too close to the statutory minimum, especially given its annual downward MLR trend.

Given that CDPHP's MLR has stabilized, the Department should consider reducing its rate adjustment to protect the carrier's remaining members.

B. CDPHP estimates a high annual claim trend of 9.6 percent.

CDPHP proposed a 9.6 percent adjustment for annual claim trend, above the average sought by the individual market carriers. CDPHP also seeks a separate adjustment of 1.4 percent for GLP-1 prescriptions but does not explicitly exclude this drug class from its pharmaceutical trend. As mentioned above in Section C. of the General Comments, the Department should reject this additional adjustment to guard against duplication.

In its Narrative Summary, CDPHP attributes a portion of its high annual claim to "skyrocketing hospital costs" and attests that to "manage rising costs," it is reducing administrative expenses. But this alleged effort to manage rising is belied by its above average claims trend projection.

The Department should consider reducing its annual claim trend to 6 percent, consistent with expert national projections for 2026.

C. CDPHP's past administrative expense ratios were too high.

CDPHP seeks approval for an expense ratio of 11.5 percent for 2026, slightly below the 12 percent average request of all individual market carriers. However, it has a history of requesting much higher expense ratios than average and was approved for ratios of 13.5 percent and 13.4 percent in 2024 and 2025, respectively. These ratios contributed to the rate hikes experienced by CDPHP's members in the past two years. CDPHP states that it is "working diligently to bend the cost curve," but offers little concrete evidence in its filings regarding the nature and extent of these activities.[61]

The Department should consider reducing CDPHP's request to an individual market wide ceiling of 10 percent, in recognition of the State's health care affordability crisis.

D. CDPHP's quality and complaint data should be considered when reviewing its rate request.

The Department should carefully consider CDPHP's complaint and quality performance before approving its elevated rate request. According to the Department's Consumer Guide, CDPHP's HMO was ranked fourth out of seven HMOs in terms of handling consumer complaints, with only five out of 77 complaints upheld by the department. CDPHP ranked third out of seven in prompt pay complaints. CDPHP performs below average on external appeals, with a reversal rate of 67 percent, indicating that its care decisions are regularly reversed when reviewed by an independent medical expert.

From the consumers' perspective CDPHP's track record is average for getting timely care and strong for rating of the health plan. As for quality of care, CDPHP routinely outperforms its peer carriers on most health quality benchmarks. The Department should consider and integrate these patient-centered factors into its rate decisions.

E. Enrollees' concerns should be honored.

Historically, HCFANY compiles the concerns of individual members that are posted on the Department's website and then presents them in this section of our comments. This year, the individual comments have not yet been posted. Accordingly, HCFANY will compile these comments after they are posted and submit them under separate cover.

[61] CDPHP 2026 Plan Year Narrative Summary, page 2.