Center for Independence of the Disabled, NY ○ Children's Defense Fund-New York
Coalition for Asian American Children and Families ○ Community Service Society of New York
Consumer Reports ○ 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 York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York
Schuyler Center for Analysis and Advocacy ○ South Asian Council for Social Services ○ Young Invincibles

July 15, 2026

Kaitlin Asrow, Acting Superintendent of Financial Services
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 – Emblem (HIP) – HPHP-134946037

Dear Acting Superintendent Asrow, Deputy Superintendent 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 2027 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 Emblem's request.

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

Governor Hochul has identified the state's affordability crisis as her top priority, and this year's rate review process offers the Department an important opportunity to help address this issue.[1] **On average, the carriers are seeking a weighted average rate increase of 20.7 percent, over five times the rate of inflation**.[2] This request follows two years of large weighted average rate increases of 7.1 percent and 12.7 percent for 2026 and 2025, respectively. Between 2021 and 2026, premiums in the state have increased by 42 percent, on average. If this year's

[1] Governor Kathy Hochul, "A Note from Governor Kathy Hochul," https://www.governor.ny.gov/programs/making-new-york-state-more-affordable.
[2] U.S Bureau of Labor Statistics (2026), *Consumer Price Index*, https://www.bls.gov/cpi/.

requests are approved, it will result in an average premium increase of 64 percent over the last five years, with four carriers' premiums doubling in this period.

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 forgoing health care due to costs.[3] 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 depend on the Department to safeguard health insurance affordability through the annual prior approval process.

This general comment section describes the following conditions that are likely to influence the rates for the 2027 coverage year: (A) New York's individual market request trends; (B) changes in the individual market; (C) medical loss ratios (MLR); (D) annual claim trends; (E) administrative costs; (F) profit and surplus; (G) adjustments for cost-sharing State mandates; (H) complaint and quality data; and (I) affirmative policies the Department can embrace to control premium increases.

A. Snapshot of New York's individual market recent requests

For plan year 2027, New York's individual market carriers seek a weighted average premium increase of 20.7 percent. *See* Figure 1. New York is a large state with 12 individual on-market carriers, resulting in a highly competitive market. As a result, New York State is well-positioned to control prices that would otherwise discourage New Yorkers from purchasing coverage on the individual market.

The rate request applications range from United's proposed 52.1 percent increase to CDPHP's proposed 1.4 percent increase in premiums. In prior years, over half of consumers were insulated from premium increases because they received some form of financial assistance. However, subsidies provided through temporary enhancements to the Affordable Care Act, called enhanced Advanced Premium Tax Credits (eAPTCs or American Rescue Plan Subsidies), expired at the end of 2025.[4] Around 19,000 New Yorkers left the market due to this shift, and over 50,000 enrollees lost financial assistance since May of last year.

[3] "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.

[4] 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.

Figure 1. 2026 and 2027 Individual Market Rate Requests				
Carrier	*2026 Members (Market Share)*	*2026 Approved Rate Increase*	*2027 Proposed Rate Increase*	*2027 Monthly average premium if approved (difference from 2026)*
United	6,300 (3%)	9.1%	52.1%	$1,778 (+$609)
Fidelis	72,100 (37%)	2.9%	28.4%	$838 (+$185)
Emblem	2,400 (1%)	-9.0%	26.8%	$1,834 (+$387)
Highmark	2,700 (1%)	19.4%	23.8%	$1,268 (+$244)
Oscar	8,100 (4%)	3.5%	23.8%	$1,294 (+$249)
Excellus	17,300 (9%)	20.7%	17.2%	$1,098 (+$161)
MetroPlus	4,100 (2%)	4.4%	17.0%	$1,185 (+$172)
Healthfirst	32,300 (17%)	9.0%	14.9%	$1,010 (+$131)
IHBC	4,100 (2%)	20.8%	14.2%	$984 (+$122)
Anthem	22,700 (12%)	4.6%	11.3%	$1,026 (+$104)
MVP	18,600 (10%)	7.4%	10.7%	$952 (+$92)
CDPHP	2,700 (1%)	12.1%	1.4%	$1,006 (+$13)
Total/ Weighted Average	**193,550**	**7.1%**	**20.7%**	**$1,005 (+$172)**

New York's individual market carriers have a history of seeking larger premium increases than are ultimately approved. Historically, the Department has scrutinized the carriers' outsized rate requests, often paring them back by roughly 50 percent or more (e.g., plan years 2026, 2023, 2022, 2021, 2019). *See* Figure 2.

Figure 2. New York Individual Market Requested vs. Approved Premium Increase			
Plan Year	*Requested Change*	*Approved Change*	*Percent Change*
2026	13.5%	7.1%	-47.4%
2025	16.5%	12.7%	-23.2%
2024	20.9%	13.5%	-31.8%
2023	18.6%	9.6%	-46.4%
2022	11.2%	3.7%	-68.9%
2021	11.8%	1.8%	-86.8%
2020	9.2%	6.8%	-23.9%
2019	23.7%	9.0%	-62.0%

Nationally, the average premium for a benchmark plan in 2026 is around $600. In New York, the average premium for a benchmark plan is $817, making it the sixth most expensive state for marketplace insurance in the country.[5] If the carriers' rate requests are approved, premiums would increase by around $2,000 per person per year.

New York carriers' rate changes typically exceed those in other states (except in Washington State in 2026), making it a national outlier. *See* Figure 3.[6] Centers for Medicare & Medicaid Services (CMS) has approved a 2.5 percent increase for Medicare Advantage plans for 2027.[7]

Figure 3. Rate Adjustments in Comparable State Individual Markets

	Approved Rate Change 2025	*Approved Rate Change 2026*	*Average Request 2027*	*Individual Market Size*	*Number of Carriers (on Exchange)*
Washington	10.7%	21%	22.4%	250,000	12
New York	12.7%	7.1%	20.7%	193,370	12
Maryland	6.2%	13.4%	13.7%	239,700	6
Massachusetts	7.9%	13.4%	12.9%	697,848	8
Oregon	8.3%	9.7%	17.5%	140,000	4
Medicare Advantage	3.7%	5.1%	2.5%	--	--

For the 2027 plan year, HCFANY urges the Department to consider substantially reducing the carriers' requests in light of the State's current affordability crisis.

[5] *Average Marketplace Premiums by Metal Tier, 2026*, 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.

[6] Washington: Washington State Office of the Insurance Commissioner. (2026). *Thirteen health insurers request average 22.4% rate increase for 2027 individual market*. https://www.insurance.wa.gov/about-us/news/2026/thirteen-health-insurers-request-average-224-rate-increase-2027-individual-market. New York: New York State Department of Financial Services. (2026*). Summary of 2027 requested rate actions: Individual and small group medical insurance*. https://myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/summary-of-2027-requested-rate-actions. Maryland: Maryland Insurance Administration. (2026). *Health Carriers Propose Affordable Care Act Premium Rates for 2027*. https://insurance.maryland.gov/Pages/newscenter/Health-Carriers-Propose-Affordable-Care-Act-Premium-Rates-for-2027.aspx. Massachusetts: Commonwealth of Massachusetts. (2026). *2027 health insurance rates*. https://www.mass.gov/info-details/2027-health-insurance-rates. Oregon: Oregon Department of Consumer and Business Services. (2026). *Reinsurance program supports affordability as insurers file 2027 health insurance rates*. https://apps.oregon.gov/oregon-newsroom/OR/DCBS/Posts/Post/reinsurance-program-2027. Medicare Advantage: CMS. (2026). *2027 Medicare Advantage and Part D Rate Announcement*. https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-rate-announcement.

[7] *2027 Medicare Advantage and Part D Rate Announcement,* Centers for Medicare & Medicaid Services, April 6, 2026, https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-rate-announcement.

B. Changes in the individual market

New York's individual market currently covers approximately 193,600 people, down from 240,200 people last year. *See* Figure 4. Federal changes to funding and coverage continue to impact New York's individual market in three ways: (i) the expiration of eAPTCs; (ii) the return of the Essential Plan (EP) 200-250 federal poverty level (FPL) population to the individual marketplace, and (iii) HR1 changes to APTC eligibility.

Figure 4. Enrollment in New York's Individual Market (On-Market Carriers)		
Plan Year	*Number of People Enrolled*	*Percent Change*
2026	193,400	-19.5%
2025	240,100	-21.8%
2024	307,000	29.4%
2023	237,300	-9.3%
2022	261,700	0.2%
2021	261,200	-19.1%
2020	322,800	-0.2%
2019	323,500	--

i. Expiration of eAPTCs (American Rescue Plan subsidies)

In 2021, Congress expanded health insurance coverage affordability by creating eAPTCs to help individuals and families purchase health insurance on the marketplace under the American Rescue Plan and subsequently extended them under the Inflation Reduction Act. These eAPTCs expired at the end of 2025, a change the Department estimated would result in 50,000 enrollees leaving the individual market.[8] Since last year, around 46,600 enrollees have left the market, and 56,000 fewer enrollees are enrolled in QHPs with financial assistance.

The Congressional Budget Office (CBO) anticipated that this attrition would be comprised of healthier-than-average people and that insurers would accordingly raise premiums by 4.3 percent in 2026.[9] Several carriers cite this estimate in their 2027 rate applications; however, this number is likely an overestimate, as many individuals who lost eAPTCs exited the

[8] 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.

[9] 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.

market before the start of the 2026 plan year. The Department has already granted all requested adjustments for this population shift for 2026. *See* Figure 5.

Figure 5. Adjustments for Expiration of ARP & Membership			
	Membership Change, 2025 to 2026	*2026 Approved Adjustment*	*2027 Requested Adjustment*
United	303	5.0%	12.7%
Emblem	-47	4.3%	7.7%
Fidelis	-23,489	4.6%	7.0%
MVP	-503	5.0%	6.8%
Healthfirst	-10,719	4.3%	4.3%
CDPHP	-417	4.3%	4.3%
IHBC	-3,247	2.3%	3.8%
Anthem	-1,996	3.1%	3.6%
Oscar	-786	--	3.2%
MetroPlus	-1,550	2.5%	3.1%
Highmark	-484	2.5%	2.0%
Excellus	-3,760	1.6%	1.6%
Weighted Average	-46,681	3.7%	5.4%

The Department should set a ceiling of 1.2 percent if an additional upward adjustment is deemed appropriate for the 2027 plan year. This recommendation is based on the methodology used in Highmark's actuarial memorandum, where one third of the impact of the expiration of eAPTCs is attributed to 2027, based on CBO and Wyman projections. Accordingly, the ceiling for this adjustment should equal one-third of the weighted-average adjustment granted to individual market carriers for the expiration of eAPTCs in 2026.[10]

ii. Return of the Essential Plan 200-250 FPL population

On July 1, 2026, 444,000 New Yorkers lost eligibility for EP coverage due to termination of the 1332 Waiver. Terminating the waiver allowed New York to leverage its $8.9 billion trust fund to maintain EP coverage for 1.3 million enrollees with incomes up to 200 percent of the FPL, but it also changed the program's eligibility rules.

Some of the 444,000 who lost coverage are expected to return to the individual market to enroll in Qualified Health Plans (QHPs), likely counterbalancing the number leaving the market due to the expiration of eAPTCs.

[10] *See* Highmark Actuarial Memrandum, p. 9.

One-third of the carriers claimed no adjustment for the migration of the EP 200-250 population to the individual market, citing either that their plans are too costly for this group or that the health of the transitioning population is comparable to that of the pre-existing risk pool.[11] Some sources suggest that this migration may strengthen the risk pool, as lower-income individuals on the EP are typically younger and healthier than those on QHPs.[12] In addition, low-income individuals are less expensive to insure. The American Academy of Actuaries stated, "lower-income individuals have … a significantly higher threshold for determining when a service is sufficiently valuable to be utilized. As such, we would generally anticipate much lower utilization among low-income enrollees."[13]

For carriers that propose EP-related rate adjustments, the requested range was -4.4 percent to 3.6 percent, with more carriers requesting a negative adjustment than a positive one. *See* Figure 6.

Figure 6. Adjustments for Return of 200-250 FPL	
Carrier	*Adjustment for 200-250*
Highmark	3.6%
Oscar	2.8%
Fidelis	1.0%
CDPHP	--
Excellus	--
Emblem	--
MetroPlus	--
Anthem HP, LLC	-1.6%
IHBC	-1.7%
MVP	-3.0%
Healthfirst	-4.0%
United	-4.4%
Weighted Average	-0.9%

Accordingly, the Department should impose a minimum of a 2.9 percent downward adjustment (the average of all carriers with a negative request) and approve all downward adjustments that exceed 2.9 percent (MVP, Healthfirst, and United).

[11] *See* IHBC Actuarial Memorandum, p. 8 & MetroPlus Actuarial Memorandum, p. 7.
[12] Empire Center (2023). *The Wacky Math of New York's Essential Plan*. https://www.empirecenter.org/publications/the-absurd-math-of-new-yorks-essential-plan/. Fiscal Policy Institute (2025). *Republican Cuts to the Essential Plan Could Cost New York Over $10 Billion a Year*. https://fiscalpolicy.org/republican-cuts-to-the-essential-plan-could-cost-new-york-over-10-billion-a-year.
[13] *Comments on the 2021 Risk Adjustment Model Update Technical Paper*. American Academy of Actuaries. November 2021. Page 6. https://actuary.org/wp-content/uploads/2021/11/Academy_Comment_Letter_CCIIO_RA_Technical_Paper_11.24.21.pdf.

iii. HR1 Changes to APTC Eligibility

On January 1, 2027, New Yorkers with incomes above 100 percent of the FPL will become ineligible for federal APTCs due to their immigration status as a result of the implementation of HR1. Two groups impacted by this change will need to decide whether to purchase individual market coverage in 2027: (i) 40,000 New Yorkers with incomes between 200 and 250 FPL who lost EP eligibility in July 2026, and (ii) 15,000 New Yorkers already on QHPs who will lose their PTC starting in 2027.[14]

The 40,000 New Yorkers who lost EP coverage in July 2026 may choose to purchase individual market coverage while they are eligible for APTCs from July to December 2026; however, starting in 2027, this group will also face much higher premiums and may self-select out of the individual market for the 2027 plan year. The 15,000 New Yorkers already on QHPs will face the difficult decision of whether or not to maintain their coverage at much higher premiums in 2027. The Department should keep this additional context in mind as it evaluates potential changes to individual market membership in 2027.

C. Medical loss ratios

The carriers' MLRs indicate the proportion of revenue spent on health care for members versus administrative costs and profit/surplus. In the wake of the COVID-19 pandemic, some carriers had high MLRs, contributing to an average actual MLR of 94 percent for 2021 and 2022. The Department approved aggressive rate increases intended to shrink MLRs.

But many of these rates appear overaggressive in hindsight, leading to loss of membership. *See, Figure 7, e.g.,* Emblem (or HIP), CDPHP. Aggressive rate hikes based on MLR concerns have led many carriers to fall below the statutory minimum of 82 percent: Emblem and Fidelis (NYQHC) in 2024; MetroPlus, Emblem, Fidelis, Oscar, and IHBC in 2025; and CDPHP and Emblem in projections for 2026. *See* highlighted cells in Figure 7. By 2025, the market average MLR (excluding United) stabilized at 84 percent , and the carriers project an average MLR of 91 percent for the 2026 plan year.[15]

Figure 7. Medical Loss Ratios in New York's Individual Market, 2023-2027

Carrier	*2023*	*2024*	*2025*	*Projected 2026*	*Requested 2027*
Healthfirst	87%	88%	90%	92%	91%
Anthem	91%	87%	83%	94%	90%
Highmark	121%	134%	99%	100%	89%
CDPHP	100%	95%	86%	**75%**	89%

[14] Benjamin, E. and Wagner, M. *Mitigating the Impact of HR 1 on New York's Health Insurance Landscape*, Community Service Society of New York. March 2026. https://smhttp-ssl-58547.nexcesscdn.net/nycss/images/uploads/pubs/CSSNY_Preserving_Health_Coverage_March_2026.pdf.

[15] United was an outlier and excluded from the weighted average. If included, the weighted average for 2025 actual MLRs is 85 percent, and the weighted average for 2026 projected MLRs is 93 percent.

Excellus	97%	101%	94%	87%	89%
MetroPlus	96%	87%	**79%**	86%	88%
United	88%	97%	111%	111%	88%
MVP	94%	90%	88%	87%	86%
Emblem	116%	**72%**	**52%**	**63%**	85%
Fidelis	91%	**76%**	**81%**	96%	84%
Oscar	91%	87%	**81%**	93%	82%
IHBC	116%	94%	**76%**	87%	82%
Weighted Average	**94%**	**86%**	**85%**	**93%**	**87%**

For the 2027 plan year, several carriers seek unnecessarily low MLRs. For example, United requests a 52.1 percent rate increase to drive its MLR from 111 percent in 2025 to 88 percent in 2027. Despite low actual MLRs reported for 2025, IHBC and Oscar have requested an MLR of 82 percent for 2027, the minimum allowable MLR required by the Affordable Care Act and State law.

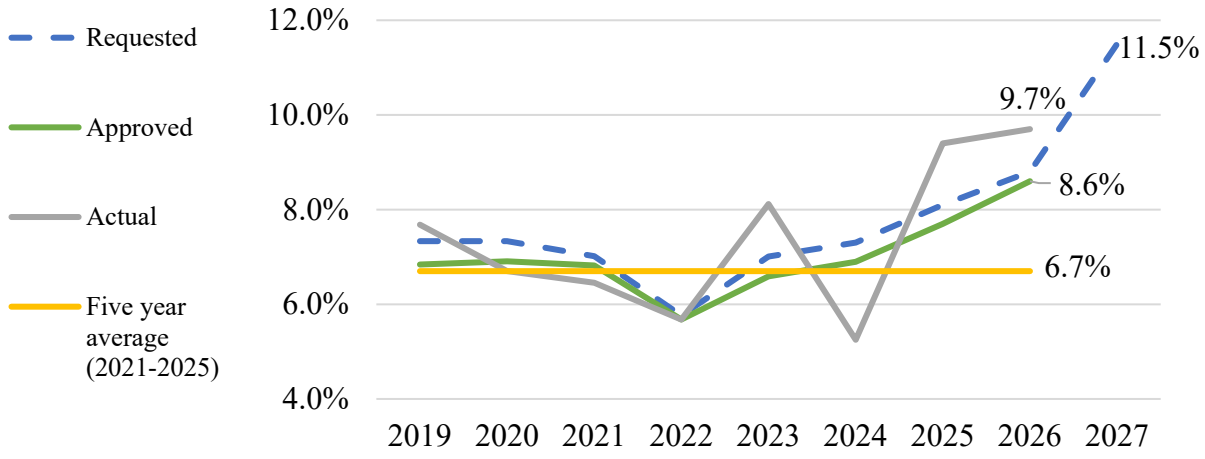
Low MLRs resulting from overly aggressive rate increases harm patients, who end up overpaying for coverage for several years. The regulatory remedy, rebates, are only paid out based on a three-year average, leaving many consumers paying overpriced premiums for years. HCFANY encourages the Department to keep this in mind when approving rate increases, to ensure carriers do not overcharge patients for coverage.

The Department should evaluate the carriers' requested MLRs for the 2027 plan year and return to its historic practice of protecting consumers by curbing the carriers' proposed requests.

D. Annual claim trend

The annual claim trend is the portion of the rate request based on changes in prices and utilization. It is the role of insurance companies to spread risk and aggregate enrollees' bargaining power by negotiating reasonable prices with providers, drug makers, and medical equipment manufacturers. New York's carriers submitted inconsistent annual claim trend estimates, indicating that many have not effectively controlled health care costs.

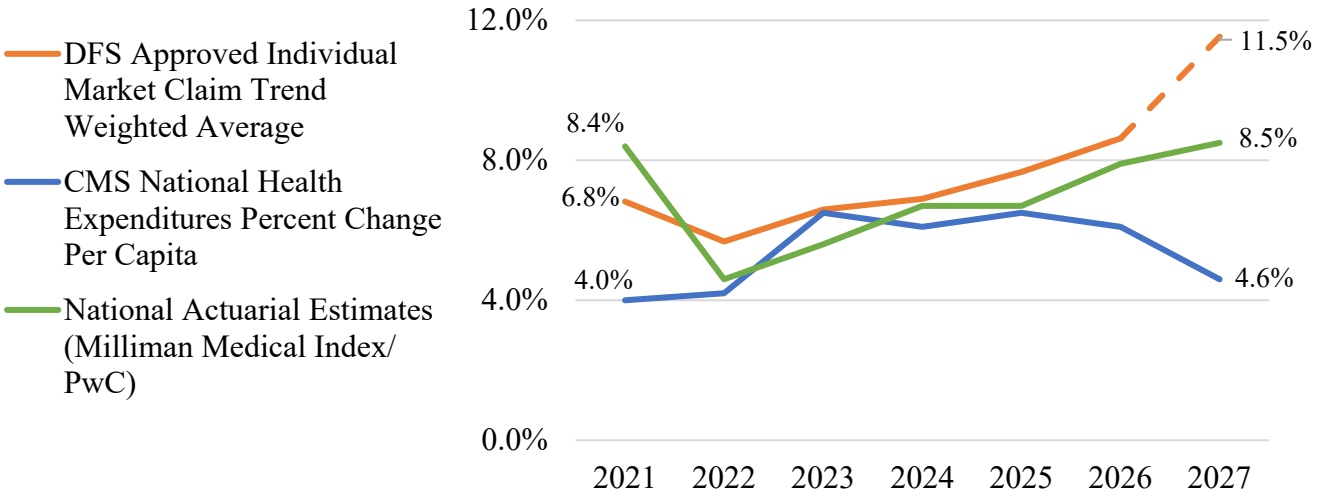
Figure 8A. Individual Market Annual Claim Trend



Without intervention from the Department, individual market carriers in New York have been unable to adequately control costs. The carriers' estimates for 2027 trend range from 8.9 percent to 14.7 percent, with a weighted-average trend rate of 11.5 percent. This trend appears inflated and is a significant jump from the 6.7 percent approved trend over the past five years. *See* Figures 8A and 8B.

Figure 8B. Annual Claim Trend by Carrier		
Carrier	*NYS DFS Approved Claim Trend 5-year Average (2021-2025)*	*Estimated Annual Claim Trend for 2027*
IHBC	5.1%	14.7%
Healthfirst	6.1%	13.6%
Excellus	6.0%	12.1%
Fidelis	6.8%	12.0%
Emblem	7.8%	11.3%
United	7.8%	11.3%
Highmark	7.4%	11.2%
MetroPlus	7.7%	10.7%
CDPHP	6.7%	10.2%
Anthem	7.4%	9.8%
MVP	6.9%	9.6%
Oscar	5.5%	8.9%
Weighted average	**6.7%**	**11.5%**

Figure 9. Medical Trend National Data and New York's Individual Market



The medical trend in New York has been climbing since 2022 and has exceeded national standards (CMS, Milliman Medical Index) since 2023. If the Department granted the carriers' weighted-average request for an 11.5 percent claim trend for 2027, it would be 2.5 times the CMS-projected change in national health expenditures.[16] *See* Figure 9. The Department should consider why New York's trend requests deviate significantly from national benchmarks and identify program bills that can help control future costs. *See* Section I.

HCFANY thanks the department for carving out GLP-1s from pharmaceutical trend this year. The carriers' adjustments in this category vary widely, with a third including no GLP-1 adjustment. This may be partly due to cost offsets. Though the landscape of GLP-1 utilization is rapidly changing, initial evidence indicates medical utilization offsets led to a 4 percent reduction in emergency department visits and reduced inpatient admissions for cohorts using GLP-1s.[17]

The Department has a critical role in controlling health care cost inflation. It is commendable that in 2025, it capped the claim trend. However, with inflation stabilizing (and even declining) and the reasons described above, the Department should cap the trend at the five-year approved average for each carrier for the 2027 plan year.

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[16] Figure 9 represents a combination of historical trend data and projections. For 2027, the DFS Individual Market weighted average is based on carrier requests in the PY2027 applications. See Centers for Medicare and Medicaid Services web tables. CMS.gov. NHE projections tables. Baltimore (MD): CMS; Available for download from: https://www.cms.gov/files/zip/nhe-projections-tables.zip. Milliman Medical Index (2021-2026), Milliman, https://www.milliman.com/en/Periodicals/Milliman-Medical-Index#sortCriteria=%40m_artdate%20descending. PwC Medical Cost Trend (2027) Behind the Numbers, PwC, https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html.

[17] 2026 Milliman Medical Index. https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/2026_Milliman-Medical-Index.pdf.

E. Administrative costs

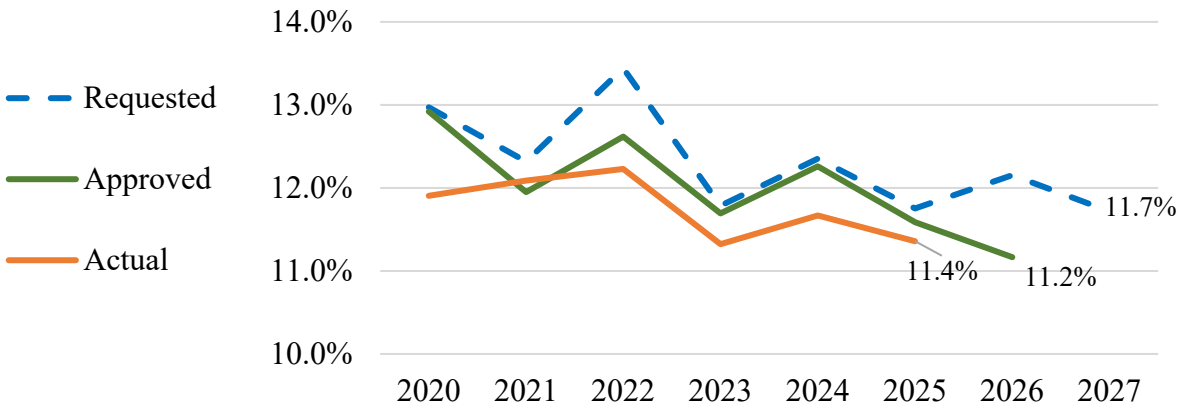
The carriers seek to spend, on average, 12 percent of their rates on administrative expenses. Since New York has a robust individual market with many carriers, the state is well positioned to improve affordability for consumers by capping administrative costs. For the 2027 plan year, IHBC seeks the largest administrative expense ratio, at 17 percent. For the second year in a row, Anthem expects the lowest, at 7.7 percent for 2027. *See* Figure 10.

Figure 10. Projected Administrative Costs	
Carrier	*2027 Projected Costs*
IHBC	17.0%
Oscar	14.7%
Emblem	14.3%
Fidelis	13.1%
Healthfirst	12.7%
MVP	12.0%
CDPHP	9.2%
Excellus	9.8%
MetroPlus	9.8%
United	9.7%
Highmark	8.4%
Anthem	7.7%
Average	**11.7%**

HCFANY lauds the Department for capping administrative costs and preventing them from creeping up over the past six years, despite the carriers' excessively high requests. While the carriers' requests have been higher than necessary, they have decreased over time, indicating that the Department's caps are working. *See* Figure 11.

However, in recent years the weighted average of carriers' **actual** administrative costs has fallen below rates approved by the Department. HCFANY urges the Department to investigate this apparent phenomenon to ensure savings from administrative efficiency are reflected in reduced rate increases rather than retained as profit/surplus.

Figure 11: Individual Market Weighted Average Admin Costs



The Department should consider setting an expense ratio ceiling at or below 10 percent, in recognition of the State's health care affordability crisis.

F. Profit and surplus

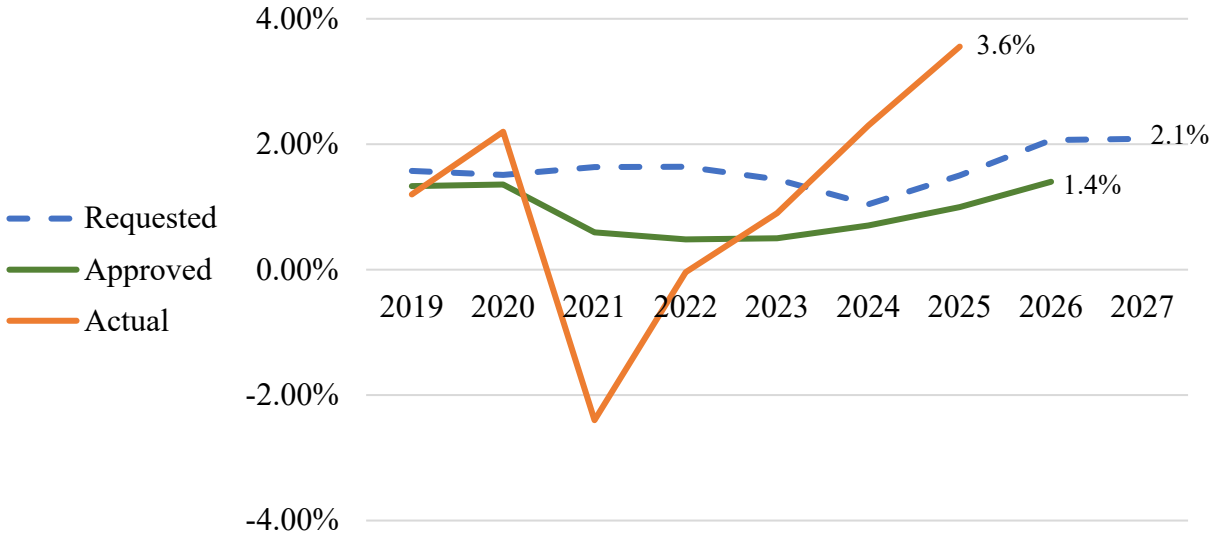
The carriers exhibit excessive variation projected profits, ranging from one to five percent. On average, carriers seek to allocate over two percent of their rates to profit. *See* Figure 12.

The Department capped approved profit and surplus at 0.5 percent for the 2023 rates, 1 percent for 2024 and 2025, and 2 percent for 2026 (excluding Oscar, which received an approved profit of 3.9 percent). However, in recent years the weighted average of carriers' actual profits exceeds rates approved by the Department. *See* Figure 13. Despite a few carriers (Anthem, Healthfirst, MetroPlus) driving this trend, HCFANY urges the Department to investigate this apparent phenomenon.

Figure 12. Projected Profit / Surplus	
Carrier	*Requested Profit/Surplus 2027*
United	5.0%
Oscar	2.8%
Emblem	2.0%
Fidelis	2.0%
Healthfirst	2.0%
MVP	2.0%
Highmark	2.0%

Anthem	1.8%
CDPHP	1.5%
Excellus	1.5%
IHBC	1.0%
MetroPlus	1.0%
Average	**2.1%**

Figure 13: Individual Market Weighted Average Profit/Surplus



The Department should consider protecting consumers by returning to its prior practice of capping profit and surplus at 0.5 percent for the 2027 plan year and enforcing this cap.

G. Adjustments for cost-sharing State mandates

The Department's instructions for the 2026-27 rate applications allow several adjustments for State mandates, including: (i) eliminating cost-sharing for insulin; and (ii) the impact of other legislative changes. The medical literature indicates that eliminating cost-sharing for chronic conditions significantly increases medication adherence, improves health outcomes, and reduces claims costs.[18]

No carriers claimed an adjustment to offset the impact of $0 cost sharing for insulin, even in the absence of reimbursement through IRIP. For the 2026 plan year, only half of the market claimed this adjustment, with the weighted average of those requests being under 0.1 percent.

[18] 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.

In addition to eliminating cost sharing for insulin, which took effect in 2026, New York also eliminated cost sharing for inhalers, effective in 2027. Only two carriers (Anthem, CDPHP) mentioned an adjustment for this legislation, and only CDPHP specified the amount of their adjustment, at 0.2 percent. Similarly, two carriers (Anthem, Highmark) claimed an adjustment for medically necessary epinephrine coverage, for which out of pocket costs in New York are capped at $100. Highmark specified the amount of its adjustment as 0.003 percent, or $0.05 per member per month.

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

H. Complaint and quality data

HCFANY also urges the Department to incorporate its complaint and quality information into the rate review process. HCFANY thanks the Department for working on revisions to the Consumer Guide to include complaint and quality data for *all plans* available in the individual market. However, based on 2026 membership counts, 77 percent of the individual market remains enrolled in plans omitted from the Guide's quality measures. Individual market products offered by Anthem, Healthfirst, MetroPlus, and NYQHC are entirely omitted from the Consumer Guide. HCFANY urges the Department to work closely with the DOH to finalize these changes and ensure that the Consumer Guide serves the consumers most likely to use it: those enrolled in the individual market.

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 2027-28 Executive Budget or through its own program bills. New York's individual market has the fewest enrollees in a decade, in part due to rapidly rising premiums. In the carriers' 2027 rate applications, high health care costs are cited as a key driver of rising premiums. As was described in last year's comments, HCFANY has compiled several affirmative cost-control measures adopted by other states that New York could pursue.

- **Invest in Primary Care by establishing primary care spending benchmarks through prior approval.** New York should follow the lead of at least 17 states that have enacted laws or issued regulations to increase primary care spending over time.[19] Rhode Island and Delaware enforce primary care investment benchmarks through prior approval.[20]

[19] 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.

[20] 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).

- **Publish New York's All Payer Database (APD).** 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.[21] The Department should work with Department of Health regulators to support the implementation of this 2011 law, launch a public-facing APD, and make data to inform price controls accessible to regulators. **The Department could leverage this data to inform its own prior approval analysis** to ensure that individual market and small group rates reflect trend and other costs in an accurate, fair and transparent manner.
- **Establish an Independent Office of Health Care Affordability.** In California, the legislature established an independent Office of Health Care Affordability to set a benchmark for the growth of health care costs, access consolidation, and uphold standards for quality and equity.
- **Adopt an affordability standard with hospital price growth benchmarks.** The Department should consider advocating for affordability standards through the prior approval process, as in Rhode Island, where carriers must keep contracted hospital price increases below inflation plus one percent.[22] A 2025 Health Affairs review found that Rhode Island's affordability standards led to a nine percent reduction in hospital prices, translating into premium reductions of $1,000 per member per year.[23]
- **In consultation with the NY State of Health Marketplace, consider adopting premium alignment to maximize APTCs.** At least seven states have adopted or implemented premium alignment (Arkansas, Illinois, Maryland, New Mexico, Texas, Washington, and Wyoming).[24] In New Mexico, the approach led to a drop in the proportion of Marketplace enrollees receiving bronze and low-AV silver coverage. Texas passed a bill to institute rate review and premium alignment in 2021 and has since seen a spike in gold plan selection.[25]

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[21] 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.

[22] 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.

[23] 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.

[24] Gaba, Charles. *Premium Alignment, or how a dozen states are quietly providing ACA enrollees w/better options even in the face of expiring tax credits.* ACASignups (Blog), November 2025. https://acasignups.net/25/11/06/premium-alignment-or-how-dozen-states-are-quietly-providing-aca-enrollees-wbetter-options.

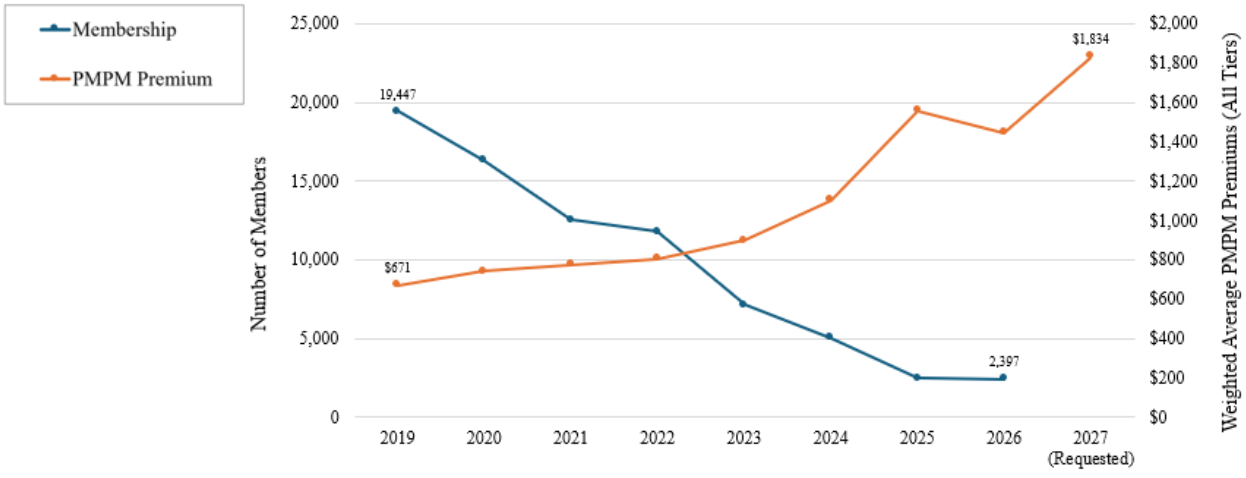
[25] Dorn, Stan. *How New Mexico Dramatically Reduced Marketplace Deductibles At Zero Cost To The State*. Health Affairs. July 2022. https://www.healthaffairs.org/content/forefront/new-mexico-dramatically-reduced-marketplace-deductibles-zero-cost-state. Birenbaum, Gabby. *Texas' ACA enrollment shrinks by 4% after tax credit expiration, new federal data shows.* Texas Tribune. July 2026. https://www.texastribune.org/2026/07/09/texas-aca-obamacare-health-insurance-effectuation/.

II. Emblem (HIP)

Emblem (or HIP) is a non-profit HMO health plan serving consumers living in Albany, Syracuse, Long Island, Mid-Hudson, New York City, and Utica/Watertown regions. As of 2026, it has just 2,397 members remaining in its individual market plans, down from 19,447 in 2019. Consequently, it now has the lowest enrollment of any carrier in the individual market. Emblem projects receiving the largest payment from the federal risk adjustment program, indicating that its risk pool is much less healthy than the overall individual market, and it will receive a payment to offset the resulting higher claims.

For 2027, Emblem is requesting a 26.8 percent average rate increase, the third highest of any carrier. Emblem demonstrates the impact of rate hikes on enrollment. When approved for a similar rate in 2024 (25.1 percent) and 2025 (35.6 percent), its enrollment dropped by 30 and 51 percent, respectively. As premiums have risen, it has lost 81 percent of its membership over the past five years, slowing only after the Department reduced its rates in the 2026 plan year. *See* Figure 14.

Figure 14. Emblem Membership and PMPM Premiums



	2019	2020	2021	2022	2023	2024	2025	2026	2027 (Requested)
MLR (Actual)	87.6%	82.0%	95.6%	104.6%	116.2%	71.7%	51.7%	62.9%	85.1%
Appoved Rate Increase	17.0%	13.5%	3.8%	1.2%	9.0%	25.1%	35.6%	-9.0%	26.8%

In 2025, the Department rejected Emblem's proposed rate increase that would have raised its premiums to an average of $1,571 per member per month. This year, Emblem's request of 26.8 percent would price the average plan at $1,834 a month before subsidies, making it about $200 higher than the rate the Department already rejected last year.

The unaffordability of Emblem's premiums is best described in their own words: "We expect most members leaving EP to be cost-conscious and seek more affordable solutions to their healthcare needs."

The Department should strongly consider imposing a negative rate adjustment, which can be achieved in the following areas: Emblem's unnecessarily low MLR goal for 2027, its administrative costs, its annual claim trend, and the unnecessary adjustments it seeks.

A. Emblem's 85.1 percent Medical Loss Ratio request is too low

Emblem projects an MLR of 85.2 percent for 2026, barely exceeding the minimum 82 percent required under New York State law. Emblem's actual MLR for 2024 and 2025 fell below the state-mandated threshold at 71.7 percent and 51.7 percent, respectively. It is true that Emblem experienced a high MLR in 2022 and 2023, but subsequent rate increases have more than offset those losses.

From 2023-2025, Emblem averaged an actual MLR of only 79.9 percent. Along with having the highest premiums, Emblem's projected MLR for 2026 is the lowest of all carriers at 62.9 percent. All but one other carrier have projected at least 85.7 percent (higher than Emblem's 2027 request) for their 2026 MLR.

In light of having posted several years of extremely low MLRs, the Department should impose a negative rate adjustment to avoid driving its few remaining members away. The Department's negative rate adjustment in the 2026 plan year helped stabilize Emblem's membership; however, Emblem continues to project an MLR that is below the statutory minimum at just 62.9 percent for the 2026 plan year.

B. Emblem is requesting one of the highest expense ratios at 14.3 percent

Emblem seeks approval for an expense ratio of 14.3 percent for 2026, well above the 11.7 percent average request of all individual market carriers.

From 2019 to 2023, the Department approved Emblem's requested expense ratio ranging from 13 to 14.9 percent, an above-average rate compared to other carriers. In 2024 and 2025, Emblem increased its requests to 17.2 and 15.9 percent, and the Department approved a 13.5 percent ratio in both cases. Despite the Department's determination, Emblem's actual expense ratios in those years matched its original requests, rather than the Department's approved ratios.

The Department should consider reducing Emblem's expense ratio to 10 percent, in recognition of the State's health care affordability crisis.

C. Emblem's estimated 11.3 percent annual claim trend is higher than any approved trend in the last seven years

Emblem's rate application seeks an annual claim trend adjustment of 11.3 percent for 2027. Emblem has a history of requesting claim trends far above the carriers' average. Emblem's 2026 plan year trend request remains well above its five-year approved average (7.8 percent), five-year actual average (11.2 percent), and 2025 approved rate (9 percent).

As described above in the General Comments, the Department should consider reducing Emblem's trend adjustment to 7.8 percent, consistent with a five-year average of its approved claim trend.

D. Emblem's adjustment for the expiration of the eAPTCs is too high

Emblem requests the second-highest adjustment for the expiration of the eAPTCs, at 7.7 percent. It cites a 2024 CBO projection on how carriers *may* adjust rates in response to the eAPTC expiration. This dated projection should not be interpreted as a recommendation from the CBO. The 7.7 percent adjustment is well above the average adjustment requested for the termination of the eAPTCs, and Emblem is the only carrier to entirely base its adjustment on this value.

As described above in the General Comments, Emblem's adjustment is likely an overestimate, and the Department should set a ceiling of 1.2 percent for the adjustment.

E. Emblem's additional adjustments should be rejected

Emblem seeks several unnecessary adjustments in its 2027 rate application, including upward adjustments for: (i) reduced utilization reviews, (ii) gene therapy, and (iii) its population with HIV.

i. Limitations on utilization reviews are likely to lead to *savings,* not increased costs

Emblem seeks an upward adjustment of 0.49 percent due to New York State legislative changes not reflected in the experience data. Emblem claims that the State mandate limiting the number of utilization reviews required for insured individuals with chronic health conditions will cost money. But it offers no concrete information as to how this mandate will increase Emblem's costs. Research from the American Medical Association indicates that prior authorizations actually **increase** costs for patients, physicians, and insurance companies alike.[1] Accordingly, the Department should be imposing a *downward*, not upward, adjustment for this legislative change to reduce the number of prior authorizations.

ii. There is no evidence that gene therapy will affect Emblem's costs

Emblem is the only carrier seeking an adjustment for gene therapy. Emblem notes in one section that their adjustment is applied to cover "expected costs" associated with gene therapy despite previously writing that this would be a "rare event."[2] Emblem is seeking this adjustment for the ***potential*** discovery of these "extremely rare" treatments.[3] Emblem's 2,397 members make up just one percent of the individual market enrollees. None of the other carriers, which have more members and are thus more likely to be impacted by the new mandate and potential cases of gene therapy, have requested either adjustment. Accordingly, HCFANY urges the Department to reject this adjustment.

iii. Adjustment for Emblem's HIV population is already accounted for and should be rejected

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[1] "Prior authorization delays care- and increases health care costs," August 2024, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-delays-care-and-increases-health-care.
[2] HIP 2027 Rate Application, Actuarial Memorandum, pages 5 and 11.
[3] HIP 2027 Rate Application, Actuarial Memorandum, page 2

Emblem also requests a 1.04 adjustment for their above-average HIV population, but this factor is already included in their federal risk adjustment, which is the highest of any individual carrier. Emblem also cites PrEP medication costs to justify the requested adjustment, although this should be covered by the federal risk adjustment, according to CMS.[4] Furthermore, PrEP is primarily a preventative medication, and increased utilization has proven to be effective in ***decreasing*** costs associated with HIV treatment.[5] Accordingly, HCFANY urges the Department to reject this adjustment.

F. Emblem's quality and complaint data should be considered when reviewing its rate request

The Department should carefully consider Emblem's complaint and quality performance before approving its elevated rate request. According to the Department's Consumer Guide, Emblem's HMO was ranked **last** out of seven HMOs in terms of handling consumer complaints, with 360 out of 619 complaints upheld by the Department. Emblem also ranked **last** out of seven for prompt pay complaints. However, Emblem performed better than average on external appeals for HMO plans, with a reversal rate of 27 percent.

From the consumer's perspective, Emblem's track record was below average for getting needed care, the health plan's rating, and access to timely care. As for quality of care, Emblem performed significantly worse than the NY HMO average for many child and adolescent health, adult health, women's health, behavioral health, and managing medications benchmarks. These included childhood and adolescent immunization and well-care visits, flu vaccination in adults, breast and cervical cancer screenings, postpartum care, and more. The Department should consider and integrate these patient-centered factors into its rate decisions.

G. Enrollees' concerns should be honored

Last, but not least, we urge the Department to consider the concerns of enrollees, who have voiced their objection to its proposed rate increase (emphasis added):

- "At a time when we as Americans are **barely able to afford our basic needs,** you are proposing to raise our health insurance premiums even more, almost certainly killing more Americans due to medical expenses. This is criminal and cruel."
- "The filing requests a 26.4% increase to my monthly premium. For my plan, that raises my premium from $1,763.55 per month to roughly $2,229 per month, an increase of about $466 each month, or approximately $5,587 per year. **An increase of this size in a single year is not reasonable**."

[4] Ratevosian et al., "Leveraging existing market incentives to increase HIV pre-exposure prophylaxis access in the United States," July 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC12215821/.
[5] "HIV+HEP Estimates HIV Cases Averted & Cost Savings Due to Long-Acting Prep," February 2024, https://hivhep.org/press-releases/hivhep-estimates-hiv-cases-averted-cost-savings-due-to-long-acting-prep/.