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 – Highmark – HLTH-134942567

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 Highmark'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.

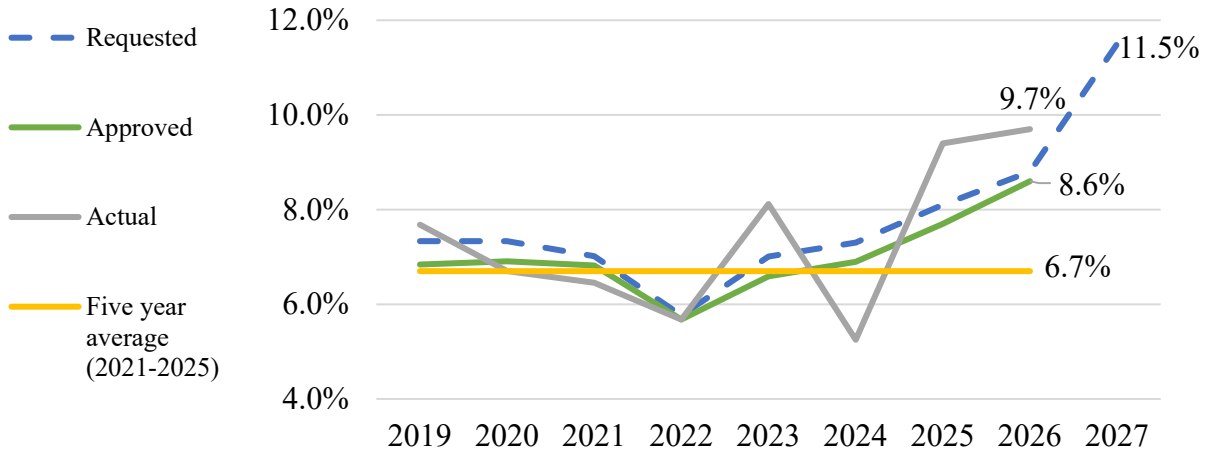
Low MLRs resulting from overly aggressive rate increases harm patients, who end up overpaying for coverage for several years. The regulatory remedy, rebates, are only paid out based on a three-year average, leaving many consumers paying overpriced premiums for years. HCFANY encourages the Department 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.

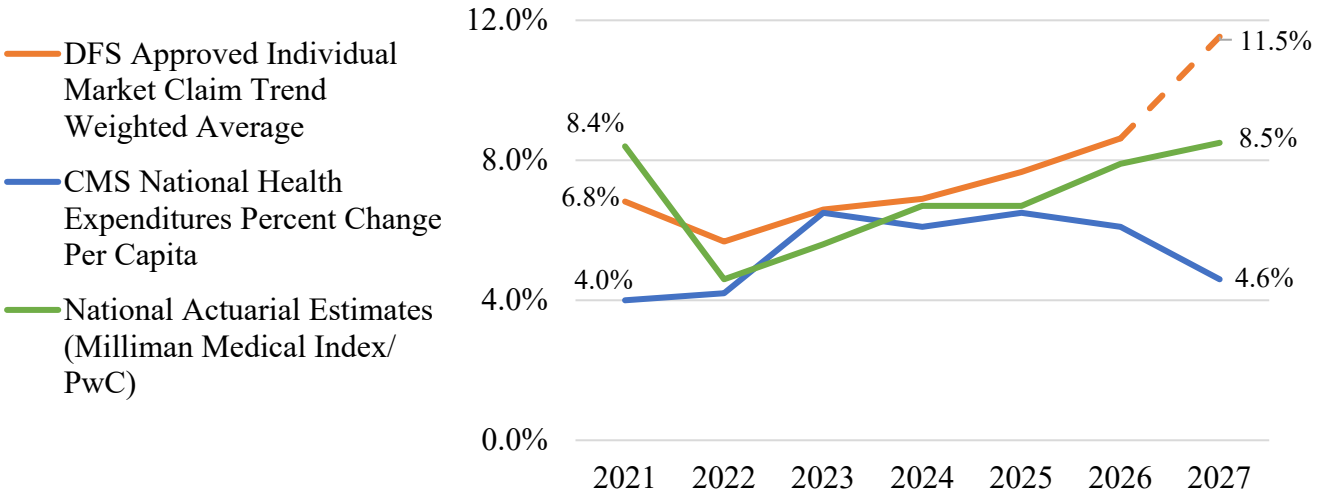
Figure 8A. Individual Market Annual Claim Trend



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

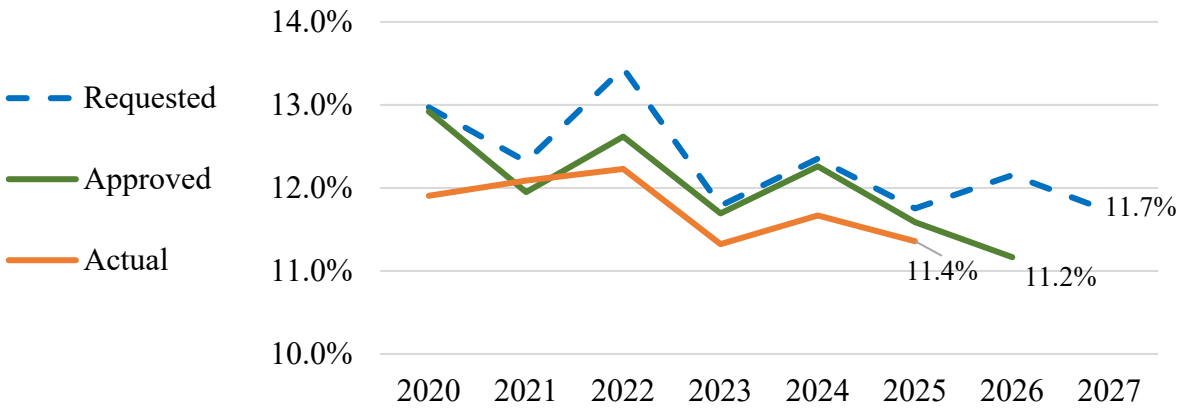
The carriers seek to spend, on average, 12 percent of their rates on administrative expenses. Since New York has a robust individual market with many carriers, the state is well positioned to improve affordability for consumers by capping administrative costs. For the 2027 plan year, IHBC seeks the largest 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

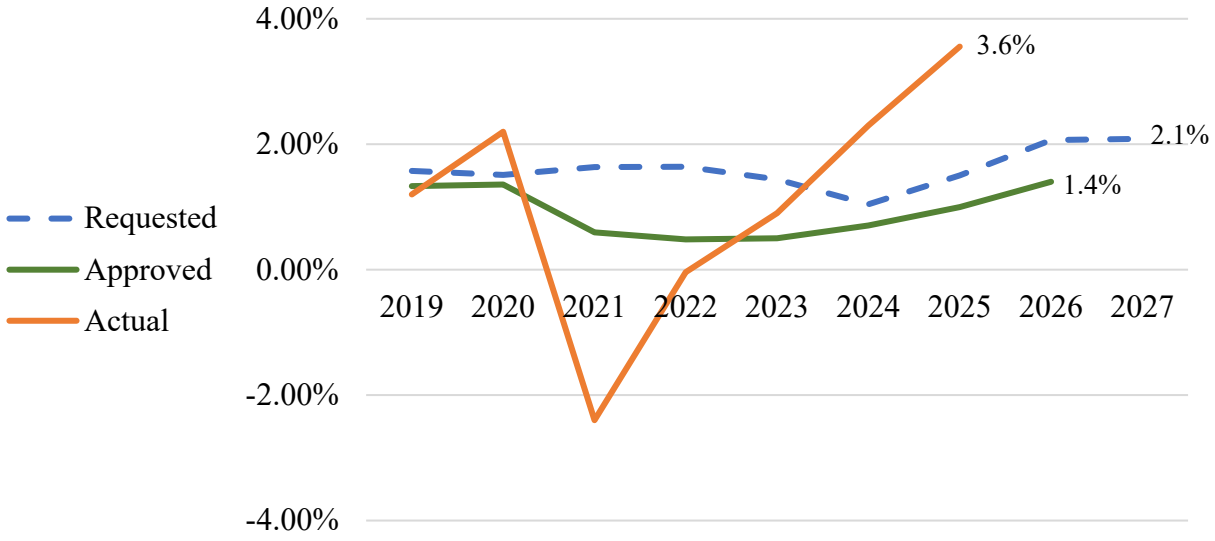
The carriers exhibit excessive variation projected profits, ranging from one to five percent. On average, carriers seek to allocate over two percent of their rates to profit. *See* Figure 12.

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.

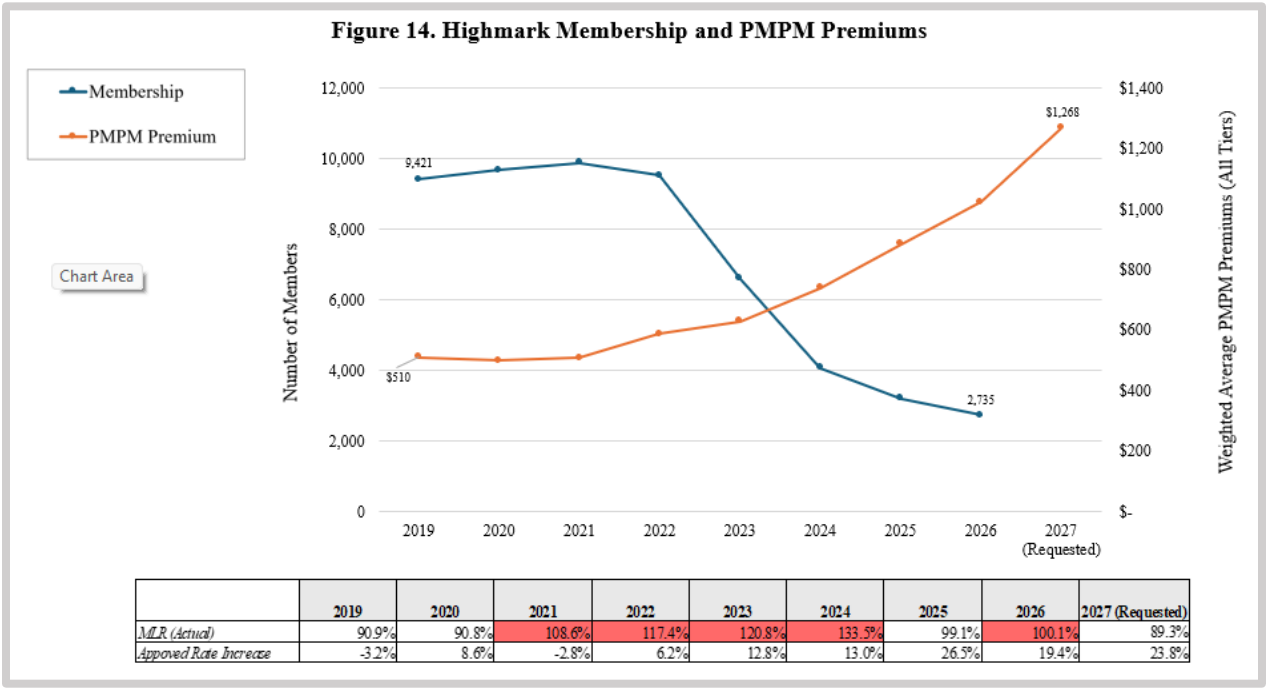
[25] Dorn, Stan. *How New Mexico Dramatically Reduced Marketplace Deductibles At Zero Cost To The State*. Health Affairs. July 2022. https://www.healthaffairs.org/content/forefront/new-mexico-dramatically-reduced-marketplace-deductibles-zero-cost-state. Birenbaum, Gabby. *Texas' ACA enrollment shrinks 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. Highmark

Highmark Western and Northeastern NY, formerly HealthNow/BCBS Western NY/BCBS Northeastern NY, is a non-profit carrier that offers EPO plans in New York's individual market. Its individual market plans serve the Albany, Buffalo, and Utica/Watertown regions. Highmark projects receiving payment from the federal risk adjustment program, which means its risk pool is less healthy than the overall individual market.

According to its filing, Highmark has 2,735 members in 2026, a 15 percent decrease in members over the prior year. It lost 72 percent of its membership between 2021 and 2026, the second-largest decline in membership in New York's individual market (after Emblem) during that period. *See* Figure 14. Highmark seeks a 23.8 percent average rate increase for 2027, the fourth highest request of all carriers and somewhat higher than the weighted market-wide average request of 20.7 percent.

Figure 14. Highmark Membership and PMPM Premiums



	2019	2020	2021	2022	2023	2024	2025	2026	2027 (Requested)
MLR (Actual)	90.9%	90.8%	108.6%	117.4%	120.8%	133.5%	99.1%	100.1%	89.3%
Approved Rate Increase	-3.2%	8.6%	-2.8%	6.2%	12.8%	13.0%	26.5%	19.4%	23.8%

If approved in full, this would mean its average premium will increase from $12,294 per year to $15,219 per year, or $1,268 per month. In other words, costs for its members would rise by $2,925 in 2027. Its members already experienced a 101 percent premium increase between 2021 and 2026—the single highest rate increase over time in the individual market.

Highmark has experienced very high MLRs over the past years. Its three-year average is 117.8 percent (between 2023 and 2025). Its MLR was 133.5 percent in 2024 but declined to 99.1 percent in 2025—a significant decrease. Highmark is aiming for an MLR of 89 percent in plan year 2027. The Department should consider the following factors to mitigate such a precipitous rate increase for its enrollees despite its elevated MLR.

A. Highmark seeks an inappropriate upward adjustment for the migration of the Essential Plan enrollees

Highmark seeks an *upward adjustment* of 3.6 percent for the projected migration of EP enrollees to the individual market. Highmark's actuarial memorandum simply describes its math formula but offers no explanation as to its methodological assumptions or the basis for the largest upward adjustment sought by any individual market carrier for this population migration.

It is well understood that enrollees with lower incomes are typically younger and healthier than their higher-income individual market counterparts. Indeed, as described in Section B, above, most carriers seek a downward adjustment for precisely this reason.

Accordingly, the Department should apply a 2.9 percent downward adjustment for the migration of the EP population to the individual market to Highmark's rate decision.

B. Highmark's proposed annual claim trend of 11.2 percent should be reduced to 7.4 percent

Highmark projects a claim trend rate of 11.2 percent for the 2027 plan year. This should be cut considerably since it is substantially inconsistent with its projected trend for 2026, which is just 6.4 percent, the lowest in the individual market applications. In 2025, it was just 3 percent. During the pandemic, Highmark saw substantially higher claim trends, but at this point, those increases are already baked into their current premium base.

Highmark's actuarial memorandum provides very little detail about why it seeks a higher-than-average claim trend. It includes a chart showing medical and pharmacy trend values, indicating that the trends for 2027 are 5.7 and 6.5 percent, respectively.

No further details are provided. The Department should require carriers to provide meaningful and specific details about their trend estimates in their actuarial memoranda.

Highmark also seeks a separate one percent adjustment for GLP-1 prescriptions. It does not provide adequate justification for this claim, citing "internal analysis" and "marketplace developments" with no detail.[1] In addition, Highmark has a track record of denying coverage of these drugs, with around 63 percent of its GLP-1 external appeals overturned between 2023-2026, according to the Department's database.

As described in section D of the General Comments, the Department should consider reducing Highmark's trend adjustment to 7.4 percent, consistent with its five-year approved claim trend average and expert projections for 2027.

[1] Highmark Actuarial Memorandum, page 5.

C. Highmark's profit adjustment should be reduced

Highmark seeks a 1.5 percent profit adjustment. For the 2025 plan year, the Department authorized Highmark a one percent upward adjustment to its premiums for profit but did not authorize a profit for 2026. Given the premium increases experienced by its membership, Highmark should again receive no profit adjustment.

As described in the General Comments, given the State's current affordability crisis, the Department should consider returning to its practice of capping profit at 0.5 percent, as it has in the past, for all carriers.

D. Highmark seeks multiple adjustments for spurious items

Highmark's rate request could be reduced below its proposed 23.9 percent increase by disallowing several small adjustments.

Highmark seeks adjustments for care that should be routinely included as regular costs of doing business as a health insurance company, such as no copays for epi-pens ($0.05) and additional breast cancer screenings ($0.62) —both of which prevent expensive hospitalizations.

Highmark also seeks a 'non-system mandates rebate' adjustment of 2.4 percent, but its actuarial memorandum provides no justification. Absent explanation and considering no other carrier took this adjustment, the Department should consider rejecting it.

Taken together, disallowing these small spurious adjustments would result in premium savings for Highmark's enrollees.

E. Highmark's quality and appeal data should be considered when reviewing its rate request

The Department should carefully consider Highmark's complaint and quality performance before approving its elevated rate request. According to the Department's Consumer Guide, Highmark's HMO was ranked third out of seven plans for handling consumer complaints, with zero of three complaints upheld by the department. Highmark ranked fifth out of seven in prompt pay complaints. Highmark performs below average on external appeals with the highest reversal rate of 85 percent, indicating that its care decisions are regularly reversed when reviewed by an independent medical expert. In terms of grievances, Highmark has a 58 percent reversal rate, suggesting that its benefit coverage is excessively limited.

From the consumer's perspective, Highmark routinely underperforms on benchmarks for child and adolescent health, adult health, women's health, and diabetes care. These include childhood immunizations, BMI percentiles, controlling high blood pressure, adult flu shots, postpartum care, and prenatal immunization status. The Department should consider and integrate these patient-centered factors into its rate decisions.

F. 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):

- "This change would increase my annual premium costs by nearly $5,000 per year, before considering deductibles, copayments, coinsurance, and other out-of-pocket healthcare expenses. I am not someone who can simply choose to go without health insurance. **I am a cancer survivor who requires ongoing medical surveillance, and my daughter also relies on this coverage. We are exactly the type of household that depends on a stable and functioning individual insurance market.**"
- "If this or any other increase is approved for them I will not only not have health insurance but I will also consider moving out of state on NY for good. My monthly premiums would stand at $2000. During last 10 years I spent $200,000 on health insurance, I consumed about $8,000 in services. **The services are getting worse and worse, fewer and fewer doctors accept this insurance**."