As many of you may know, New York State mandates that all insurance carriers notify their customers of their intent to request rate increases to the Department of Financial Services (DFS) at the same time they file those requests to the state. Many carriers file their rate increase requests in late May and early June for rates effective in January of the following year. You may have received a notice recently from your health insurance carriers.

If you have questions about Health Insurance, contact Eric Laughlin, Council Services Plus at elaughlin@councilservicesplus.com or (877) 501-4277 ext. 128.

Here are some FAQ’s to help guide your organization:

So what do these rate announcements mean?

NYS requires the insurance carriers to share their proposed rate increases they file with the Department of Financial Services (DFS) with their policyholders. It’s a nice opportunity to get a little insight into what the future may hold, but it tends to cause a lot of confusion among employers and employees. Health carriers tend to file in June for their next year’s rates. The announcement is simply an overall average of what the carrier is requesting DFS approve for them for the next year.

So are the rates the actual rates?

Not really. There are 2 important pieces of information to understand here. (1) these are average total rates increases (or decreases) for the insurance carrier’s total community rated book of businesses. Some plan types may require more than the average and others may require less, so this is a 30,000 ft view of what the company needs to get, and (2) DFS has the right to review and make changes if they feel the carrier did not calculate their rate changes in accordance with community rating rules, are too assumptive with their future claims expectations or if they feel a rate change could have significant (negative) effect on consumers.

OK, so how do we use this data?

Good question. This is an indicator of rates, so it gives us a ballpark of what to expect. For example, if the carrier is filing for a 4% increase, that tells us that their plans are running fairly well, and the increases should be relatively modest for the coming year. If the increases are 17% that could mean that the company may be needing large premium dollars to offset prior years losses. Again, these are only requested rate increases, not approved. It may not even be actually what a particular nonprofit’s plan will go up (or down).

So when does the crystal ball get clear enough to see into?

DFS has 60 days to respond to the carrier’s filings with any questions or additional data requests. If DFS does not respond the carrier moves ahead under the assumption the request is approved. That doesn’t mean we’ll know for sure by August, but the process does have some time frames. I would suspect that we would know more by September what the approvals will be. Again, these are global averages, so each nonprofit’s group plan may be a little more or a little less depending on how that particular plan went with their carrier and DFS.

Is there anything we can do from our end to address this?

Certainly, and I would encourage it. There is a 30-Day Comment Period where individuals and groups can contact DFS to submit comments about the proposed rate changes. The comments must be made within 30 days from the date of the notice that groups and individuals received. Comments on the proposed rate changes may be entered through the DFS portal on their website.

Is there anything you see here that nonprofits should be thinking about?

Yes, while upstate carriers are projecting lower increases in the single digits, it seems as though downstate will be in for
larger than average rate increases again in 2021. Carriers like Oxford, Empire, Aetna, Emblem, and Oscar are all requesting double digit increases, as high as 29.1% in the case of Oscar. Downstate organizations should prepare for larger increases and make sure their budgets can absorb those increases. If not, it may be good to have options ready to be discussed.

Any options come to your mind?

Sure. Shopping around is one option that most folks immediately think of, but that can come with its challenges. Network changes, drug formulary changes and general claims processing of a new carrier may create challenges to staff so if moving to another carrier with better rates looks good, make sure you do your due diligence to lessen the impact of the change on staff. Premium savings is one thing, but access to care and continuity of care for staff cannot be understated. Another is the use of alternative funding accounts like Flexible Spending Accounts (FSA), Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA). As nonprofits are forced to choose plans with higher deductibles or co-pays to maintain affordable health plans these accounts are being used more and more to help the out of pocket cost-shift to staff. These accounts help set money aside, on a tax-favored basis, if the employee needs services and is looking at higher out of pocket costs as a result. I think another good idea is to have honest discussions with staff about what’s going on in healthcare. The affordability issue is not just a nonprofit one, or even a New York state one, it’s a national crisis and we need to all participate in finding solutions. Staff are better off when they understand the challenge of coupling affordable premiums with out of pocket cost. When staff only see their co-pays and deductibles going up they want to advocate for keeping the same plan they have. But when they see the cost of premiums versus how they use the plan, it’s a bigger picture that helps them understand. I think education is always helpful.

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