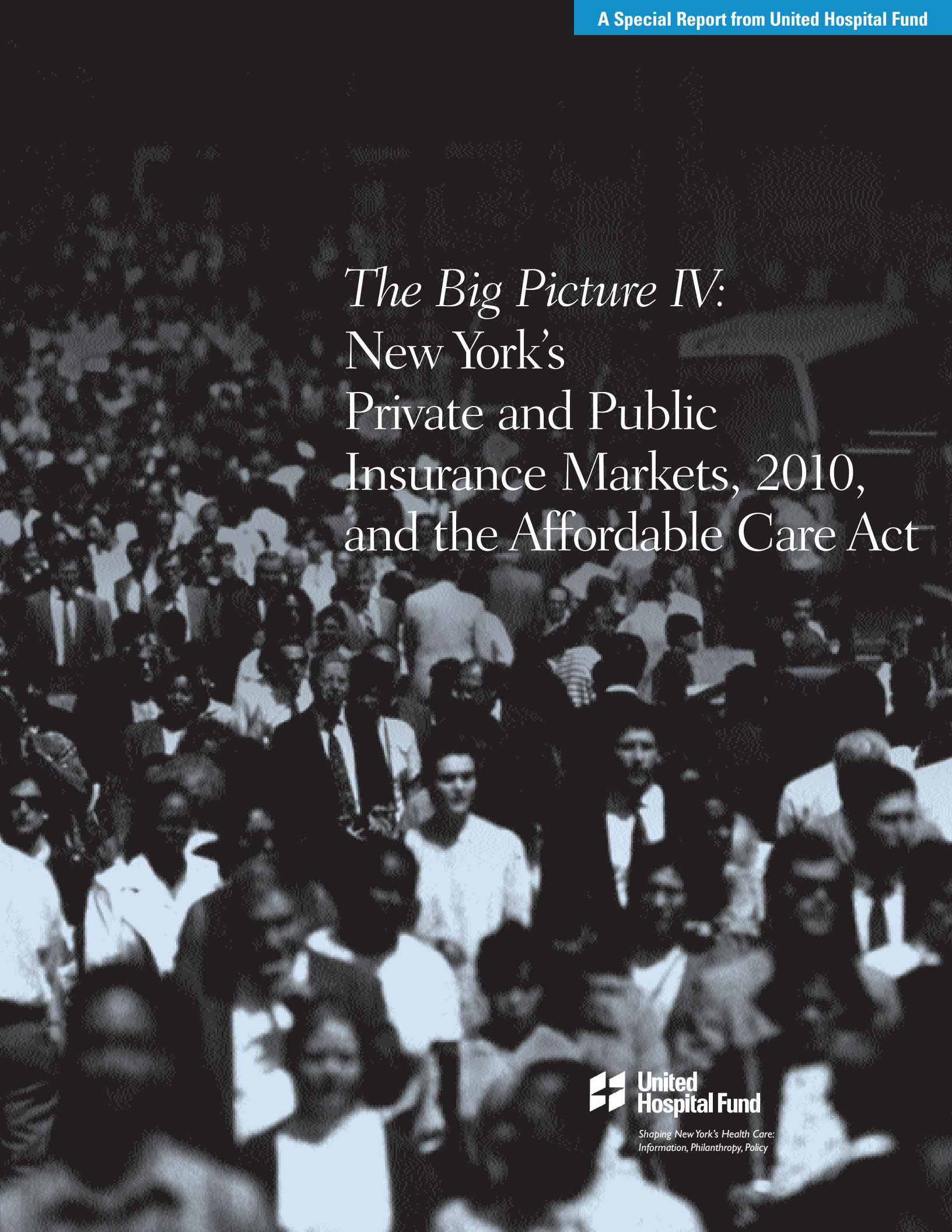
A Special Report from United Hospital Fund



The Big Picture IV: New York's Private and Public Insurance Markets, 2010, and the Affordable Care Act

United Hospital Fund

Shaping New York's Health Care: Information, Philanthropy, Policy

United Hospital Fund

The United Hospital Fund is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, health centers, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

A Special Report from United Hospital Fund

The Big Picture IV: New York's Private and Public Insurance Markets, 2010, and the Affordable Care Act

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Additional copies of *The Big Picture IV* may be downloaded from the United Hospital Fund's website, www.uhfnyc.org.

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Foreword

Where were you at 10 in the morning on Thursday, June 28? I suspect that, like many of us here at the United Hospital Fund, you were on the edge of your seat, awaiting word from the U.S. Supreme Court on the fate of the Affordable Care Act.

While from a national perspective, the Medicaid portion of the decision was unexpected, the court's affirmation of the individual and small group market reforms —health benefit exchanges, individual responsibility requirements, premium and cost-sharing tax credits for individuals and small businesses—was very good news for New York. In this fourth installment of the Fund's *Big Picture* analyses of public and private insurance markets, supported this year by the New York State Health Foundation, the authors review 2010 enrollment and financial results for public and private insurance markets, and use them to inform a discussion of the impact of the ACA, and the important policy decisions, implementation issues, and regulatory challenges that lie ahead.

The Exchange and the subsidies that will be available will help New York tackle its most pressing problems, a dysfunctional individual market and fewer small group employers sponsoring coverage. It is a significant beachhead in New York's economic development efforts. A functioning insurance market with affordable options for purchasers will make our state a more hospitable place to live and work, and will improve the climate for small businesses, start-ups, and the young people drawn here for the many opportunities available.

As evidenced by the American Recovery and Reinvestment Act, and continuing with the ACA, New York has gained a responsive partner in the federal government. Like New York, the federal administration is intensely focused on exploring ways to bring about the service delivery, system change, and payment reforms that will improve health care's quality while keeping its costs from breaking our backs. As a result of this collaboration—and the resources the federal government has brought to bear—New York has regained the leadership role it has historically played among states.

Things could certainly change in the months ahead. The Supreme Court decision, though huge, is just one step in a political debate that will conclude at the end of this year with pressure on the government to make long-delayed decisions on spending and taxes. Putting these political considerations aside, New York faces a daunting list of implementation tasks in the months ahead. It is somewhat comforting to view the enormous task at hand in simpler terms that have guided our work here at the Fund, and longstanding state efforts as well: provide a good array of affordable health coverage choices for individuals and families, identify the ones that are the best fit, and help them enroll. With the tools provided by the ACA, these goals are in sight.

James R. Tallon, Jr.
President
United Hospital Fund

Acknowledgments

We are grateful to the many people at the New York State Department of Health (DOH) and the New York State Department of Financial Services (DFS) who provided additional data and background information. Representatives of individual health plans also provided important clarifications.

Methodology

The major data sources for this report were annual statements for calendar year 2010 filed by health plans with the National Association of Insurance Commissioners (NAIC); New York State supplements filed with the New York State Insurance Department; Medicaid Managed Care Operating Reports filed by Prepaid Health Services Plans (PHSPs) and Health Maintenance Organizations (HMOs) with the New York State Department of Health; and, for Medicare Advantage plans, enrollment reports and data available online from the Centers for Medicare & Medicaid Services (CMS). Filings from New York-licensed insurers and national insurers admitted in New York were obtained. Although NAIC and New York Supplement reports for calendar year 2011 were available in March 2012, Medicaid Managed Care reports lag behind the NAIC and New York State Supplement reports by several months. In order to provide a complete annual snapshot of health plans enrollment and financial reports, we relied on calendar year 2010 reporting, except where noted.

Under NAIC reporting requirements, different requirements apply to different kinds of insurers. HMOs have the most detailed reporting requirements, and national life, accident, and health insurers the least. These limitations are reflected in this report. Also, as opposed to census data, health plans report group enrollment based on the location of the business rather than the residence of the enrollee, so New York enrollment figures cited here capture a significant number of out-of-state residents insured through employment with New York businesses. Finally, enrollment figures reflect some double-counting due to various practices—for example, products for which two separate licensed insurers provide in-network and out-of-network benefits; or arrangements in which one insurer underwrites a hospital benefit and separate insurers underwrite the outpatient, prescription drug, or mental health benefits. We tried to make adjustments for these practices where possible, and we have noted instances where they might occur.

Because of the enactment of the Affordable Care Act and new federal responsibilities for insurance regulation, in 2010 health plans were required to include a new supplementary exhibit to their NAIC statements so that federal and state regulators would have a better handle on enrollment, financial results, and loss ratios. In a number of areas, this supplement provides long overdue uniformity and clarity to health plan reporting. The supplement has its limitations, however, and in order to preserve the ability of readers to make year-to-year comparisons with previous reports, we have preserved the general format but selectively refer to the new NAIC supplement.

Introduction

This fourth installment in our annual examination of New York's private and public insurance markets is grounded on an analysis of health plan enrollment and financial results for calendar year 2010, based on publicly available filings to state and federal regulators, in addition to other sources. Our findings are loosely organized by three market segments—Medicare, state public managed care programs, and commercial coverage—and according to the four types of licensees doing the business of insurance in New York: Health Maintenance Organizations certified under Article 44 of the Public Health Law; similar entities known as Prepaid Health Services Plans participating only in public programs; nonprofit insurers organized under Article 43 of the Insurance Law; and for-profit Life, Accident, and Health insurers governed by Article 42 of the Insurance Law.

With this analysis as a foundation, we also examine the prospective impact of the landmark Affordable Care Act (ACA) on New York's health insurance markets, and review some of the important policy questions and regulatory challenges ahead.

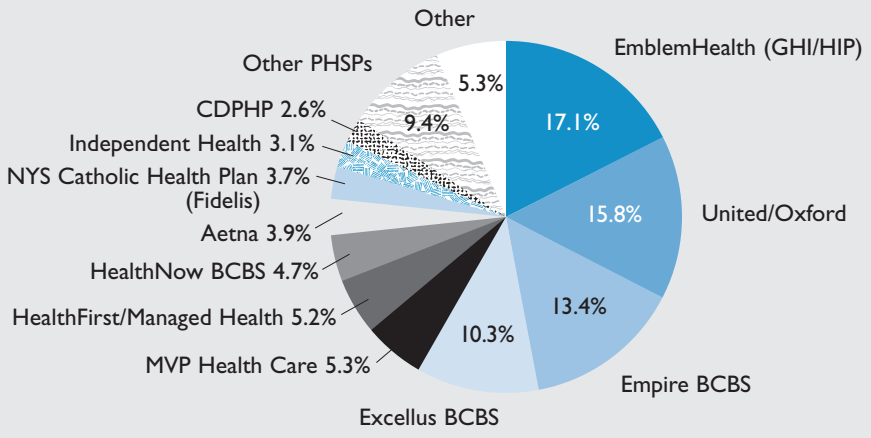
Overview

Premiums

Premiums for all plans totaled almost $51.3 billion in 2010 (Figure 1), a 3.3 percent increase from 2009. While New York's "Big Four" group of commercial health plans—Empire BCBS, UnitedHealthcare (Oxford), EmblemHealth (HIP and GHI), and Excellus BCBS—again accounted for about 57 percent of total premiums, EmblemHealth's share increased modestly (to 17.1 percent), and United/Oxford's share increased by over 2.5 percentage points (to 15.8 percent), as Empire BCBS's share dropped by 3 percentage points (to 13.4 percent).

The striking growth of the PHSP sector

Figure 1. **Health Plan Market Share Based on Premiums, 2010**

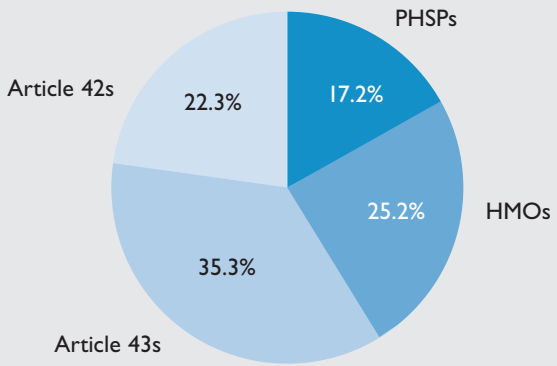


Notes: Represents premiums totaling $51.3 billion. Includes all health premiums reported in health plan annual statements, including dental, vision, and disability. Results for separately licensed subsidiaries operating in New York and controlled by a common parent company are combined.

Sources: Authors' analysis of health plan annual statements, exhibit of premiums, enrollment, and utilization; for national insurers, NAIC annual statements, Schedule T, premiums collected in New York State; for PHSPs, Medicaid Managed Care Operating Reports filed with the State Department of Health.

continued in 2010. Total premiums for PHSPs, which specialize in public programs, exceeded $8.2 billion in 2010 (Table 1), a jump of more than 20 percent from 2009, which increased the sector's overall market share by nearly three percentage points. PHSPs now take in more than 17 percent of premiums overall (Figure 2), while shares for the HMO and Article 42 sectors declined and Article 43s stayed about the same between 2009 and 2010. Premium revenues for PHSP Fidelis Care approached $2 billion in 2010 (Table 1), making it one of the largest managed care organizations in the state of any kind; with only public program business, it earned a higher percentage of New York premiums than two mainstays of the upstate commercial and public program market, Independent Health and CDPHP. When public program premiums for HealthFirst PHSP are combined with revenues from Medicare Advantage business through its HMO licensee (Managed Health Inc.), the company's premiums exceed $2.6 billion (Table 1). Its 5.2 percent share of total premiums leave it just shy of being the fifth largest insurer in the state, and with a greater market share than both national insurer Aetna and HealthNow BCBS in western New York (Figure 1).

Figure 2. **Share of Premiums by Health Plan License, 2010**

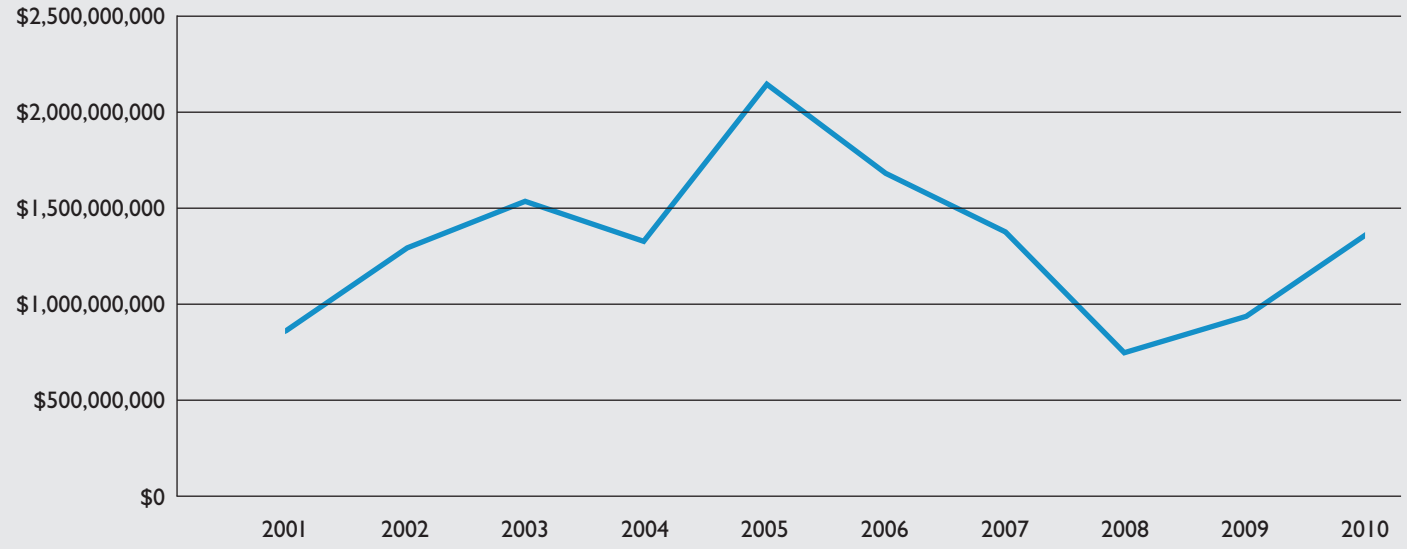


Notes: Based on total premiums of $47.97 billion, which does not include some premiums from national life and health insurers.

Sources: Health plan annual statements, statement of revenues and expenses, and Medicaid Managed Care Operating Reports to New York State Department of Health.

Despite declining enrollment, health plans serving the commercial market increased profitability significantly above 2009 levels, recording over $1.3 billion in net income, nearly a 50 percent increase (Figure 3). When positive results from PHSPs are added in, the total jumps to over $1.5 billion (Table 1). Profitability in Medicare Advantage business, discussed below, accounted for a major share of health plan profits, particularly for their HMO licensees, despite ongoing reductions in federal premiums for coverage that are continued and broadened in the ACA.

Figure 3. **Net Income for New York Health Plans, 2001 to 2010**



Note: Total net income in 2010 of $1,368,267,060 (excludes PHSPs).

Source: Authors' analysis of health plan annual statements and New York State supplements.

Enrollment

Total enrollment at HMOs and Article 43 and 42 insurers declined from 12,267,305 in 2000 to 10,985,781 in 2010 (Table 2), but much of the decrease is attributable to a business decision by a single health plan to shift significant membership from its fully insured book of business to a self-funded arrangement. This restructuring by Empire BCBS[1] of its New York City public employee business rippled through many statistical categories for commercial enrollment in 2010. Small group enrollment continued to show some resiliency in 2010, but individual enrollment continued its slow, steady decline, as monthly premiums for individuals enrolled in the standardized HMO products now exceed $1,000 for most health plans in all parts of the state for basic HMO coverage.[2]

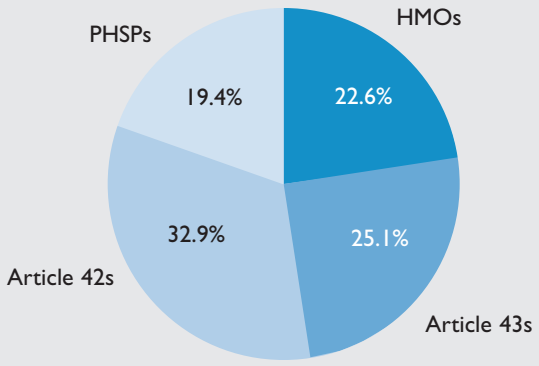
While commercial enrollment declined, enrollment in New York's public programs—Medicaid Managed Care (MMC), Family Health Plus (FHP), and Child Health Plus (CHP)—continued its steady march upward (Table 2). With the state and national economy still struggling, MMC enrollment grew by more than 7 percent to over 2.8 million in 2010. Reflecting the growth in these public programs, total PHSP enrollment increased by over 8 percent from 2009 to 2010, while membership in the other three categories of licensees declined (Table 2). Enrollment share by license reflects a complex dynamic (Figure 4). As enrollment in PHSPs grows, and commercial enrollment declines, PHSP market share of total enrollment grows; it reached over 19 percent in 2010, an increase of nearly three percentage points.

1 Personal communication with representatives of Empire BCBS, March 6, 2012.

2 Premium Rates for HMO Standard Individual Health Plans by County. New York State Department of Financial Services. Available at http://www.dfs.ny.gov/insurance/ihmoindx.htm (accessed July 10, 2012).

Growth in Medicare Advantage business and state public programs helped HMOs offset the continuing loss of commercial enrollment and the ongoing migration of HMO business to more flexible licenses, and helped them maintain their market share position in 2010 (23 percent). Among HMOs, only Oxford Health Plans HMO bucked the trend of declining commercial enrollment, adding more than 30,000 commercial members in 2010. Reflecting the commercial business development at Empire BCBS, the Article 42 insurer share of enrollment dropped a full four percentage points (to 33 percent).

Figure 4. **New York Enrollment by License Share, 2010**



Notes: Total enrollment of 13,632,346. See Methodology for explanation of how insurers calculate enrollment. Vision- and dental-only enrollment not included.

Sources: Health Plan annual statements, New York State supplements.

Medicare

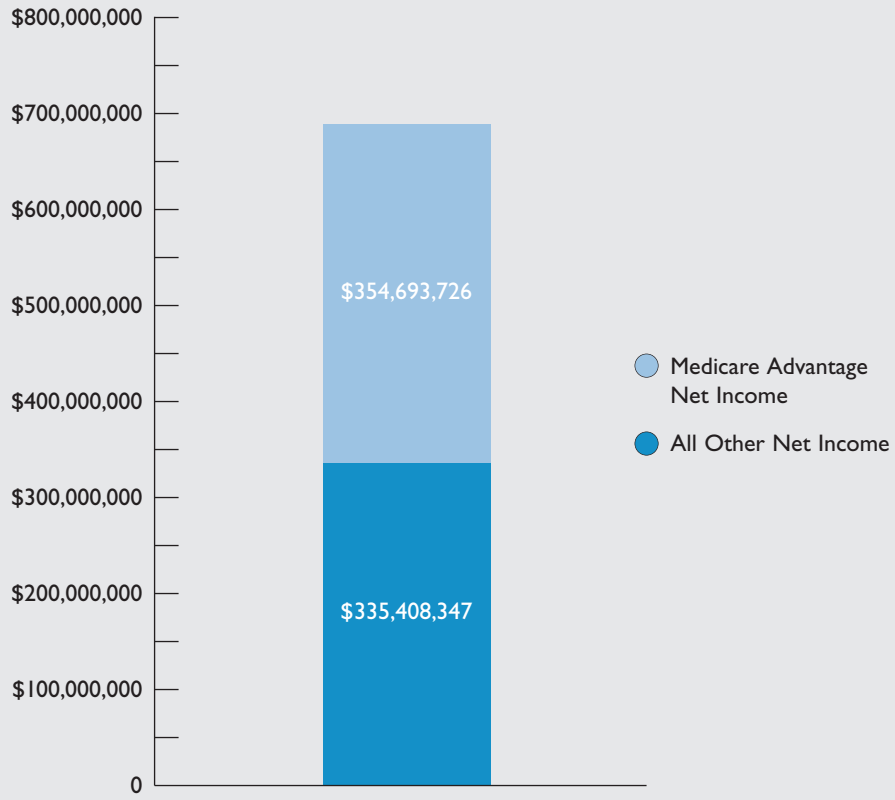
Medicare Advantage

Enrollment in Medicare Advantage plans grew by over 4 percent from 2009 to 2010, reaching nearly 900,000 enrollees (Table 3). Nearly 75 percent of those members were enrolled in the HMO option, but growing numbers joined local and regional preferred provider organizations (PPOs); enrollment in local PPOs grew by over 70,000 in 2010. At the same time, enrollment in the private fee-for-service option continued its decline to less than 27,000, as only a single insurer, American Progressive, offered a plan with significant enrollment.

Despite an 8 percent drop in enrollment in 2010, EmblemHealth companies retained the largest share of Medicare Advantage enrollment in New York: nearly 140,000 members (15.6 percent of total market), followed closely by UnitedHealthcare companies (111,318), which grew by nearly 11 percent in 2010. Managed Health Inc., part of the HealthFirst holding company, had the largest enrollment of any PHSP or PHSP-affiliated plan, and was the fourth largest overall.

Medicare Advantage continues to be a consistent source of profitability across all sectors (Table 4). For HMOs, the business

Figure 5. **Medicare Advantage Share of 2010 HMO Underwriting Gains**



Sources: Analysis of New York State supplements; for Accident and Health insurers, NAIC annual statement, page 7.

produced net underwriting income of about $355 million, just over half of total net underwriting gains for HMOs ($690.1 million) in all lines of business (Figure 5). HMO line-of-business plans for Article 43 insurers reported another $106.5 million in gains from Medicare business, and Article 42 insurers reported about $40.4 million, bringing the total to over $500 million for the three categories of licensees (Table 4).

Reflecting the higher medical needs of a program for the elderly and disabled, HMOs participating in the Medicare Advantage program reported an average premium of $1,072.44 per member per month (PMPM), average medical expenses of $912.89 PMPM, and medical loss ratios (MLRs) that averaged 85.1 percent (Table 5). But there are some eye-opening positive results in the Medicare Advantage health plan reports, including an average spread of $159.55 PMPM, average net income of $56.70 PMPM, and a solid average operating margin of 5.3 percent, with only four of 17 plans posting negative margins. In contrast to the overall net income for Medicare Advantage plans, HMOs, Article 43 line-of-business HMOs, and PHSPs reported net income of $170.6 million for MMC enrollees, despite a considerably larger enrollment base.

Whether these profitability levels will be sustainable is an open question, given the payment reductions for plans contained in the ACA. Though many predicted dire

consequences for consumers enrolled in plans, a recent survey of the New York Medicare Advantage Plan market for 2011 found that Medicare beneficiaries enrolled in New York plans did not experience significant benefit decreases or increased costs.[3]

Medicare Part D Prescription Drug Coverage

Enrollment in stand-alone prescription drug coverage through Medicare Part D grew by less than 2 percent in 2010, to 990,635 (Table 6). UnitedHealthcare companies retained the top spot in enrollment, growing by about 10 percent to reach over 225,000 members in 2010, roughly 23 percent of the overall market. CVS Caremark was the second-largest Part D plan (169,011 members) in 2010, but its acquisition of Universal American subsidiary American Progressive (114,234 members) in 2011[4] suggests the combined companies will be more competitive with United going forward. Life insurer CIGNA, despite winding down the affairs of its HMO licensee in New York in 2010, also grew its Medicare prescription drug plan business in 2010, earning it the fourth-highest enrollment total. Some of these enrollment increases may have come at the expense of EmblemHealth companies, which experienced an enrollment decline of more than a third, from 127,360 to about 83,000.

Medicare Supplement

In 2010, over 330,000 New Yorkers were enrolled in Medicare Supplement insurance plans (Table 7),[5] which insure against cost-sharing provisions in traditional Medicare Part A (hospital) and Part B (outpatient) insurance. Enrollment declined by over 56,000 from the previous year, reflecting a national trend in declining Medicare Supplement enrollment and increasing Medicare Advantage enrollment since 2005.[6]

The implementation of the Medicare Advantage program and the drug coverage made available through the Medicare Part D program have limited the attractiveness of Medicare Supplement coverage. A number of potential developments going forward could also affect enrollment. The federal budget proposal for fiscal year 2013 includes a provision to assess a surcharge on beneficiaries who purchase "near first-dollar" Medicare supplement insurance policies in 2017.[7] The proposed surcharge would affect new beneficiaries and is designed to offset the perceived overutilization by enrollees purchasing coverage under "C" and "F" plans, which reimburse policyholders for nearly all of the cost-sharing required under traditional Medicare. The surcharge would add an amount equal to approximately 15 percent of the average Medigap policy premium onto a member's Medicare Part B premium, about $30 more per month,[8] and is associated with an estimated $2.5 billion in savings over a

3 Goggin-Callahan D. June 2012. *New York's Medicare Marketplace: Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform*. New York: Medicare Rights Center.

4 CVS Caremark. Press release, April 28, 2011. "CVS Caremark to Complete Acquisition of Universal American's Medicare Part D Business." Available at http://info.cvscaremark.com/newsroom/press-releases/cvs-caremark-complete-acquisition-universal-americans-medicare-part-d-busine (accessed July 23, 2012).

5 Personal communication with the Department of Financial Services, June 18, 2012. Enrollment as of December 31, 2010.

6 Sheingold S, A Shartzer, and D Ly. December 2011. *Variation and Trends in Medigap Premiums.* Available at http://aspe.hhs.gov/health/reports/2011/MedigapPremiums/index.shtml (accessed July 31, 2012).

7 Budget of the United States Government, Fiscal Year 2013. Available at http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf (accessed June 16, 2012).

8 In 2010, Medigap policyholders paid an average premium rate of $178 per month. Jacobson G, T Neuman, T Rice, K Desmond, and J Huang. September 2011. *Medigap Reform: Setting the Context.* Menlo Park, CA: Henry J. Kaiser Family Foundation. Available at http://www.kff.org/medicare/upload/8235-2.pdf (accessed July 17, 2012).

10-year period. A similar proposal, assessing a 20 percent surcharge on average Medicare Supplement and employer-sponsored retiree plans, is included in the Medicare Payment Advisory Commission (MedPAC) annual report to Congress.[9] This proposed surcharge would affect current Medigap and employer-sponsored retiree plan enrollees, and, if implemented, would increase Medigap payments by an estimated $420 per year.[10]

New York State Public Managed Care Programs

Enrollment in New York State's three major public managed care programs (Medicaid Managed Care, Family Health Plus, and Child Health Plus) grew by more than 220,000 in 2010 (Table 2). With no major changes in eligibility criteria, this 6 percent increase is likely attributable to a still-slumping state economy; in 2010, approximately 8.3 percent of New Yorkers were unemployed at year's end—only a slight improvement from the previous year, in which unemployment had reached its highest level since 1983.[11] The lion's share of the enrollment increase came in the MMC program, which grew by over 192,000 members to reach over 2.8 million. With modest growth in FHP (18,816) and CHP (10,846), enrollment in these three major state public managed care programs eclipsed 3.6 million. About three-quarters of enrollees in MMC and FHP were enrolled in PHSPs as opposed to HMOs, but only just over half of CHP members were enrolled in PHSPs.

Medicaid Managed Care

Fidelis Care was the largest beneficiary of increased MMC enrollment in 2010, growing to 478,408 members, a 23 percent increase over 2009, while HealthFirst added over 30,000 new members (Table 2). Together, the two PHSPs control over 30 percent of MMC enrollment statewide. Fidelis's MMC enrollment exceeds the total enrollment in all programs by every commercial HMO except for HIP. All together, MMC enrollment in commercial HMOs increased by just over 19,000 in total. HIP remains the largest MMC commercial HMO, with over 217,000 members in 2010; UnitedHealthcare HMO (the successor to Americhoice PHSP) is a close second, with over 211,000.

HMOs reported over $46.8 million in net income from underwriting in 2010 for their MMC business (Table 4), as six of nine HMOs writing the business posted profits, led by UnitedHealthcare's HMO, which reported over $38.4 million in net income. Article 43 line-of-business HMOs recorded $27.8 million in gains, led by HIP's $19.8 million in net income. All told, six of 11 PHSPs reported positive net income for MMC business, for a total of $95.9 million, with MetroPlus ($55.1 million), Fidelis ($19.7 million), and Affinity ($13.1 million) posting the highest gains.

As noted earlier, PHSPs write much more MMC business than HMOs do; there are some other differences between the two licensees as well. PHSPs posted lower average operating margins (1.9 percent versus 2.7 percent for HMOs), higher average medical loss ratios (89.4 percent versus 85.5

9 Medicare Payment Advisory Commission. June 2012. *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, D.C.: Medicare Payment Advisory Commission.

10 Beneficiaries included in the MedPAC analysis were enrolled in both Part A and Part B for the full year 2009 and were not enrolled in private Medicare plans or Medicaid.

11 United States Department of Labor, Bureau of Labor Statistics. Local Area Unemployment Statistics Map, New York, December 2010 (seasonally adjusted). Available at data.bls.gov/map (accessed June 16, 2012).

percent for HMOs), and lower average net income ($4.76 PMPM compared to $7.09 PMPM) (Table 8). Nonprofit Univera Community Health posted the largest margin in the PHSP sector (5.2 percent), followed by nonprofit Fidelis Care (4.1 percent); for-profit HMO United Healthcare posted the largest margin in the HMO sector (4.8 percent), followed by nonprofit MVP Health Plan (4.4 percent). But it is also striking to compare the results of the two public managed care programs, one funded jointly by federal, state, and local governments (Medicaid), and the other by the federal government and enrollees (Medicare). The average spread of $159.55 PMPM for the Medicare plans (Table 5), noted earlier, exceeds those calculated for the Medicaid HMOs and PHSPs ($38.55 and $26.53, respectively) by many multiples. Net income results calculated on a PMPM basis also reflect this sharp difference between these two kinds of public managed care program: $56.70 for the Medicare plans, as opposed to $7.09 for the Medicaid HMOs and $4.76 for the Medicaid PHSPs.

Family Health Plus

FHP grew modestly from 2009 to 2010 (Table 2), adding only 18,816 members—still a sharp contrast to 2008-2009 results, which showed an enrollment decline of nearly a third, although many of these members transferred to MMC due to streamlined eligibility rules. The largest FHP plans included Fidelis Care (84,581 members), HealthFirst (42,707), and, among HMOs, UnitedHealthcare HMO (35,019). MMC was by far a more reliable source of income than FHP for plans, especially for PHSPs; only three of 11 PHSPs posted underwriting gains under the program, and overall, plans lost nearly $20 million on the business (Table 4).

Child Health Plus

CHP added about 10,800 members in 2010, providing services to over 406,000 kids (Table 2). Fidelis Care was the largest CHP plan in the state in 2010, with over 71,000 members. Several other PHSPs posted enrollment in the 18-28,000 member range, bringing total PHSP CHP enrollment of 226,893. Among HMOs, Empire BCBS was the largest CHP plan, with 64,139 members, followed by Excellus BCBS at 48,748. Like FHP, CHP enrollment did not generate much net income for participating health plans overall (Table 4). For example, all but three PHSPs lost money on the business, though one that posted gains (Fidelis Care) reported $3.6 million in profits for CHP.

Prepaid Health Services Plan Financial Results

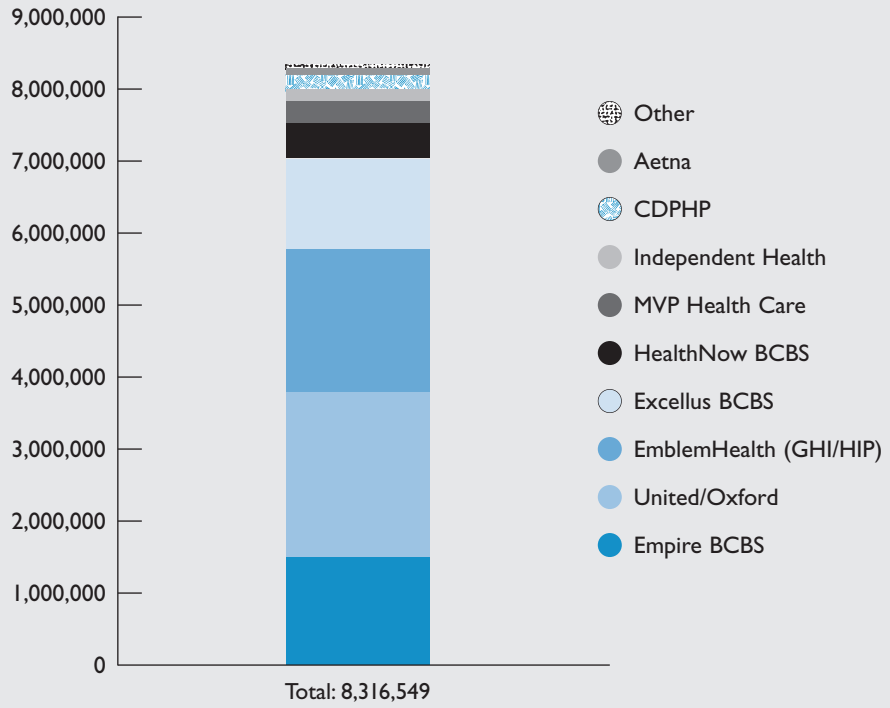
PHSPs, a segment that includes both publicly traded for-profit plans (e.g., Amerigroup) and nonprofit provider-sponsored plans (e.g., HealthFirst), reported about $135.3 million in net income in 2010, as five of the 12 plans finished in the black (Table 1). From the $8.2 billion in premium revenues they received, PHSPs earned $78.7 million in underwriting net income and over $25 million in investment income. Fidelis Care led the group with $61.8 million in net income, followed by MetroPlus ($56.3 million), a consistent performer in most public programs, and WellCare ($18.7 million). The average margin for PHSPs was 1.6 percent, and the average net income was $4.24 PMPM, but there was considerable variation in the group. MetroPlus and Univera had 4.7 percent margins, and WellCare had the third highest, 3.8 percent. With regard to PMPM statements of net income, WellCare, MetroPlus, and Univera again led the pack at $15.07, $11.93, and $11.12 respectively. One of the largest PHSPs, HealthFirst, made a modest $1.2 million in net income, for a margin of 0.1 percent. The 2010 results for PHSPs, while still quite positive historically, did not quite match 2009 levels of $168.3 million in net income, with an average margin of 2.5 percent and average PMPM net income of $5.92.

Commercial Markets

Commercial health plans reported total enrollment of 10,985,781 in 2010 (Table 2), a decline of more than 10 percent from 2009. Among licensees, the biggest decline occurred in Article 42 insurer enrollment (down nearly 19 percent), and was most evident in comprehensive group coverage, which declined by nearly 1.3 million. As noted earlier, much of the decline can be traced to Empire BCBS's book of business, where fully insured enrollment in its Article 42 license declined by 934,109 in 2010 (38 percent), with a concomitant increase in its self-funded business in 2010, from 2.85 million to 3.77 million.[12] The impact on comprehensive group enrollment is shown in Figure 6, reflecting a decrease in overall fully insured group coverage from 9.6 million to 8.3 million. While New York's Big Four insurers —Empire BCBS, Excellus BCBS, United/Oxford, and EmblemHealth—still represent almost 85 percent of the 8.3 million total, Empire BCBS's share declined considerably because of the business change.

12 Empire HealthChoice Assurance, Inc. December 31, 2010. New York State Insurance Department Annual Statement Supplement. Page NY27. Available at https://myportal.dfs.ny.gov/web/guest-applications/nysupp-public-access (accessed July 11, 2012).

Figure 6. **Employer Group Enrollment, 2010**



Notes: Limited to enrollment in HMO commercial groups; Article 43 Provider Service Organizations, PPOs, Point of Service, and Indemnity Only; and Article 42 Accident & Health large and small group comprehensive. Total enrollment is 8,316,549, likely including some enrollment in other states and some double-counting due to both health plan reporting methods and the joint delivery of comprehensive benefits to employer groups by more than one health plan. Results for separately licensed subsidiaries operating in New York and controlled by a common parent company are combined.

Source: Authors' analysis of health plan annual statements and New York State supplements.

Enrollment

Enrollment trends in the small group market, which has shown some resiliency of late, were more difficult to pin down. While small group enrollment is hard to identify for Article 43 insurers because of reporting differences with other licensees, declines in small group enrollment for Article 42 insurers and HMOs of 46,000 and 37,000, respectively, suggest a modest decline (Table 2). In last year's report, DFS data for calendar year 2009 pegged small group enrollment at 1.6 million. Corresponding data were not available this year, but some other sources suggest a healthier small group market. Major New York health plans reported small group enrollment of 1.74 million in a new schedule required by the NAIC beginning in 2010,[13] and in reporting required for New York's reinsurance program health plans listed 1.9 million small group members filing medical claims in 2010, though this total probably reflects claims from enrollees in two separate health plans in a single year.[14] While the exact total of small group membership is uncertain, the continuing success of Oxford and other UnitedHealthcare companies in this market is crystal clear; combined enrollment (with HealthNet subscribers included) reached nearly 600,000 enrollees in 2010 (Table 2).

Another certain fact is the continuing weakness of New York's standardized individual market, which dipped to just over 26,000 members in 2010, a 20 percent decrease from 2009, with about 60 percent of members enrolled with either Oxford Health Plans HMO or Empire BCBS HMO (Table 2).

Financial Results

Commercial health plans licensed in New York—HMOs, Article 42 insurers, and Article 43 nonprofit insurers—collected $39.7 billion in premiums in 2010. This was only a slight increase from 2009, possibly a result of the Empire BCBS self-funding arrangement that reduced overall premiums (Table 1). Article 43 insurers earned about 43 percent of those premiums, followed by HMOs (30 percent) and Article 42 insurers (27 percent). Measured on a PMPM basis (Table 9), premiums grew an average of 10.8 percent for HMOs and 4.8 percent for Article 43s. In terms of medical expenses, the average for HMOs increased by 6.2 percent and by just 2.9 percent for Article 43 insurers. Both indicators show slower average growth from 2009 to 2010 than seen between 2008 and 2009. At the same time, nearly all HMOs and Article 43s showed a healthier spread between their revenues and expenses, measured on a PMPM basis.

HMOs, Article 43s, and Article 42s paid a total of $4.38 billion in administrative expenses in 2010 (Table 10), slightly less than in 2009, which, combined with lower enrollment, led to PMPM costs about 10 percent higher than in 2009. Medical payments increased by 4.6 percent for Article 43 insurers to $14.8 billion, but they declined by more than 10 percent for HMOs (Table 11).

The improved spreads showed up in health plans' bottom lines, as net income increased from $921.7 million to $1.37 billion in 2010, well below the $2.1 billion high for the decade in 2005 but still a significant increase from 2009 (Figure 3). HMOs earned about $635

[13] UHF analysis of Supplemental Health Care Exhibit — Part 1, filed with the NAIC for calendar year 2010, as an exhibit to annual statements. Results from 25 licensed insurers and HMOs operating in New York, with a total of $39.3 billion in premiums, were considered. Obtained through Freedom of Information Law request, New York State Insurance Department, May 3, 2011.

[14] Personal communication with New York State Department of Financial Services, May 22, 2012.

million in net income (46 percent of the total), besting their 2009 total by over $122 million, followed by Article 42s with $428 million (31 percent) and Article 43s with $305 million (22 percent) (Table 1). Article 42 profits were nearly double those of 2009, and Article 43 results represented the second strong year in a row, after negative results for this sector in 2008. These net income figures are also reflected in margins: HMOs led with a 5.2 percent average, followed by Article 42s at 4.0 percent and Article 43s at 1.8 percent, about the same margin as PHSPs (1.6 percent).

In terms of profitability, Empire BCBS's HMO and Article 42 licensees led the pack. For HMOs, Empire outpaced other plans in overall profitability ($178.8 million), margin (9.1 percent), and per-member earnings ($49.40 PMPM); for Article 42s, it posted the highest PMPM results ($14.17). United/Oxford plans posted the second-strongest results generally for HMOs and Article 42s, though MVP was the second-most profitable HMO, with $124.4 million in net income. For Article 43 insurers, HIP outpaced competitors by a wide margin, posting a PMPM return of $24.39, a margin of 4.9 percent and over $239 million in net income, offsetting losses of $32.7 million for its sister company GHI (both are part of EmblemHealth).

For the three categories of licensees, underwriting income of $1.2 billion was supplemented by strong investment returns. Commercial health plans earned almost $600 million in investment income, as only one licensee among all HMOs, Article 43s, and Article 42s posted negative investment returns; Empire BCBS reported nearly $224 million in investment income for its Article 42 insurer, representing almost 80 percent of total investment income for Article 42s, certainly a major factor in Empire's bottom line.

These positive returns are also reflected in line-of-business results for the three categories of licensees. For HMOs, all plans but two posted positive results for large group business, and though only four of 11 plans posted positive returns for small group customers (led by Oxford Health Plans' $53 million profit), small group net income exceeded profits from individual business by over $20 million, a rare occurrence of late (Table 4). Empire ($32 million) and Oxford ($9.3 million) continued their strong run of profitability in the dwindling direct pay market. HMOs posted overall profits for all lines of businesses except Healthy NY in 2010.

For Article 43 insurers, net income from large group business of $253.5 million (driven by HIP's $213.8 million net) helped offset overall small group losses of $129 million, aided by continuing direct pay gains of $40.5 million, with $37.9 million of that gain reported by GHI. Excellus BCBS posted losses in small group and experience-rated business that were offset by positive returns on large group ($38.8 million) and individual ($7.5 million) business. Investment income of $68.6 million contributed a lot to this company's positive bottom line and modest margin of 0.9 percent (Table 1).

For Article 42 insurers, more limited reporting makes detailed analysis difficult, but the sector did rebound from its $19.3 million loss in comprehensive business in 2009 to post a gain of $209.7 million in 2010, led by Empire ($126.8 million), Oxford ($182.1 million), and sister company United HealthCare Insurance ($55.6 million).

This year's analysis also affords the opportunity to look at how health plans have fared in the decade between 2001 and 2010 in terms of net income. During that time, UnitedHealthcare companies were the most profitable ($4.1 billion), followed by Empire BCBS ($3.5 billion) and EmblemHealth

($1.5 billion). But underlying this comparison are the tremendous changes wrought in the commercial market over the last decade: UnitedHealthcare, HealthNet, and Oxford were commercial competitors in 2001, not members of the same holding company; HIP and GHI were nonprofit competitors, instead of affiliated companies; and Empire BCBS's conversion to a for-profit company was approved by regulators in 2002, and not upheld by the New York State Court of Appeals until 2005, followed quickly by its acquisition by WellPoint/Anthem BCBS.

In the midst of a generally positive 2010 for health plans, the picture was not completely rosy. Six of 11 HMOs lost money on small group business, six finished in the red on the Healthy NY line, and Article 43 insurers posted overall losses on small group business of nearly $130 million. But in yet another market indicator—surplus—nearly all plans beefed up their reserves in 2010 (Table 12). Overall, health plans increased reserves by 17 percent in 2010, adding almost $1.3 billion in surplus for a total of $8.8 billion. State insurance laws set minimum standards for health plans to meet in terms of surplus, in order to safeguard against insolvency. Federal regulators at the NAIC devised a complex formula, known as risk-based capital (RBC), to measure the adequacy of plans' surplus, based on their business risks and the quality of their investments. Under the NAIC formula, 200 percent RBC is the minimum surplus health plans must maintain in order to avoid regulatory intervention of some sort. In 2010, HMOs increased the RBC levels from an average of 562 percent to 607 percent, Article 43s from 476 percent to 539 percent, and Article 42s from 601 percent to 861 percent. Some plans finished 2010 many multiples ahead of the NAIC RBC minimum standard, such as Independent Health Association HMO (RBC of 1,397 percent) and UnitedHealthcare's Article 42 licensee (RBC of 3,690 percent).

Looking Ahead

Overview

Any way you look at it, the ACA will have a tremendous positive impact on New York's public and private markets. In fact, well in advance of the full implementation of the Act on January 1, 2014, it has already altered the landscape in a number of ways: improving coverage for young adults and Medicare recipients, for example, and providing significant resources for implementation and system change efforts. We conclude this market analysis by noting the ways the ACA provisions will increase access to coverage and reshape public and private markets, highlighting some important regulatory issues and discretionary decisions New York State faces. We begin by discussing some broader market issues worthy of note in a post-reform world, and then make some observations specific to the commercial market and public programs.

The Health Benefit Exchange

The linchpin of ACA insurance market reforms, the Exchange can be viewed as a distribution system overlaid on both New York's public and private markets. On the public side, it must partner with federal officials on eligibility determinations, and coexist and integrate with the state's Enrollment Center, facilitated enrollers and vendors involved with enrollment, and the new consumer assistance[15] and navigator programs created by the ACA[16] —all while

[15] Community Health Advocates. Available at http://www.communityhealthadvocates.org/ (accessed July 23, 2012).

[16] Affordable Care Act, Section 1311.

New York phases out local governments' role in Medicaid administration. For commercial coverage, the Exchange must also mesh with the existing distribution system, one in which individuals are largely left to their own devices and employer groups purchase coverage through brokers and agents known as "producers."[17]

Commission payments are unusual in New York's individual market but common in its group market; in 2010 major New York-licensed health plans reported nearly $693 million in commission expenses.[18] The Exchange, which will assume producer-like functions itself, could change this dynamic in a number of ways, since the ACA grants states broad discretion to define the role of producers in the Exchange. New York policymakers took the first steps in grappling with this issue with the publication of a consultant's report in June 2012.[19] At a time when it must plan for its own financial independence, the Exchange will need to determine whether paying commissions in either market makes sense. If it chooses to pay commissions, it must also determine whether to pay them directly or cede that role to health plans, and also the method of payment, at a time when agent compensation is gradually shifting from the traditional percentage of premium method for each "case" (or employer group) to flat PMPM fees. The Exchange will also have to integrate the navigator program, consider outsourcing Exchange functions to producers or other intermediaries, and decide whether to allow producers to act as "web-brokers" operating their own satellite exchanges. Producer compensation decisions go to the heart of the role the Exchange plays in a new distribution system, its need to ensure its own financing, and the balance between the Exchange and non-Exchange markets.

Regional Market Differences

Regional differences in New York's insurance markets have long been a source of tension. Nonprofit regional plans upstate are wary of incursions by largely for-profit, national plans concentrated in New York City and its suburbs. They emphasize other product and market differences that require special attention from regulators and policymakers, and a tailored rather than statewide approach to regulation. Since the ACA allows states the discretion to establish regional exchanges, these tensions cropped up during legislative negotiations. While New York lawmakers did not reach an agreement on Exchange legislation, one component of the bill[20] not included in the Executive Order[21] housing the Exchange at the DOH created five regional advisory committees to provide guidance for the Exchange. Although the geographic borders of the five regions—New York City, Metropolitan Suburban, Northern,

17 Newell P and A Baumgarten. October 2009. *The Big Picture: Private and Public Health Insurance Markets in New York*. New York: United Hospital Fund.

18 UHF analysis of annual statement underwriting and investment exhibit, part 3—analysis of expenses, line 3, for major health plan licensees in New York: Independent Health Association; HealthNow BCBS; MVP Healthcare (Preferred Care); CDPHP; UnitedHealthcare (Oxford); Empire BCBS; Aetna; HealthNet; EmblemHealth (HIP and GHI); and Excellus BCBS. Total does not include commissions paid by national insurers or small market share health plans.

19 Wakely Consulting Group. June 2012. *The Role of Producers and Other Third Party Assistors in New York's Individual and SHOP Exchanges*. Boston: Wakely Consulting Group, with support from the Robert Wood Johnson Foundation. Available at http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/wakely_role_of_third_party_assistors.pdf (accessed July 23, 2012).

20 Governor's Program Bill #12R,A.8514 (Morelle)/S.5849 (Seward), introduced at the request of the Governor. Available at http://open.nysenate.gov/legislation/search?term=S5849. Passed Assembly June 23, 2011; recommitted to Senate Rules Committee, June 24, 2011.

21 Executive Order No. 42 Establishing the New York Health Benefit Exchange. April 12, 2012. Available at http://www.governor.ny.gov/press/04122012-EO-42 (accessed July 23, 2012).

Central, and Western—are not specified, Tables 14 and 15 (and the accompanying map) show potential boundaries as well as the distribution of commercial group and Medicaid Managed Care coverage, respectively, within these lines. To meet less specific Executive Order requirements for regional advisory committees, New York is considering a similar five-region structure, but with Long Island as a separate region.

The for-profit/nonprofit division of downstate/upstate markets is evident, and it comes as no surprise that over half of the commercial group market comes from the New York City and Metropolitan Suburban regions (though the Metropolitan Suburban region comes closer to the New York City region in total enrollment than one might expect), and that nearly 70 percent of MMC enrollment comes from the city. The Northern region is the smallest in terms of public enrollment, and the Western has the smallest commercial enrollment. Only one region, Central, which includes both Syracuse and Rochester, features a single plan (Excellus BCBS) with a significantly higher market share than its competitors. Only one PHSP (Fidelis Care) and one commercial plan (EmblemHealth) have significant enrollment in all five regions, when adjustments for how commercial plans report public employee enrollment are made. Finally, since many enrollees will bounce back and forth between Medicaid and subsidized coverage through the Exchange as their income levels change,[22] there is a stark difference in structure between the New York City public market, dominated by PHSPs, and upstate markets, where commercial plans all participate in public programs. Upstate, most enrollees in public programs who lose eligibility for Medicaid would find it easier to enroll in Exchange-subsidized coverage with the same health plan; downstate, enrollees in similar circumstances would more likely have to switch to a different plan. These long-entrenched market patterns provide food for thought for policymakers and regulators, and perhaps some fodder too for regional advisory committees.

Consolidation

Health plan consolidation continues to reshape public and private markets, and 2010 was no exception. UnitedHealthcare finalized its acquisition of HealthNet's northeast commercial business in 2010; publicly traded PHSP Amerigroup finalized its acquisition of one of New York's leading PHSPs, HealthPlus, in May 2012,[23] and was itself the target of an acquisition by Empire BCBS parent company WellPoint in July 2012.[24]

Many analysts believe that the implementation of the ACA increases incentives for further mergers and acquisitions. Some health plans may feel the need to "get bigger" through mergers in a more competitive landscape, particularly upstate. Commercial plans looking to increase their presence in public markets, like WellPoint, may also look at the PHSP sector for entree. There is also an increased focus on consolidation by providers. In 2011, Albany's St. Peter's Hospital, itself a member of the Catholic Health East system, merged with Northeast Health, a system formed through mergers of other Albany-area hospitals and long-term

22 Buettgens M, A Nichols, and S Dorn. July 2012. *Churning Under the ACA and State Policy Options for Mitigation.* Washington, D.C.: Urban Institute for the Timely Analysis of Immediate Health Policy Issues Initiative, Robert Wood Johnson Foundation.

23 Amerigroup. Press release, May 1, 2012. "AGP Completes Acquisition of Health Plus." Available at http://www.amerigroup.com/news/agp-completes-acquisition-health-plus (accessed July 23, 2012).

24 Abelson R and MJ De La Merced. July 9, 2012. WellPoint to Acquire Amerigroup Amid Health Care Overhaul. *New York Times*.

care providers.[25] Continuing speculation surrounds the possibility of a major reconfiguration of New York City systems, perhaps involving Mount Sinai Medical Center, Continuum Health Partners, and NYU Langone Medical Center.[26]

While health care providers have long complained that insurer consolidation drives down reimbursement rates, many observers contend that as providers gain ground through mergers of their own, their increased bargaining power generates upward pressure on premiums. ACA provisions encouraging more integrated care and new ways of paying for care could further complicate the situation.[27]

Capitation, Payment Reform, and Risk

Table 11 shows the percentage of total medical payments made by HMOs and Article 43 insurers through capitation, the flat, per capita payments made to providers based on membership, not services. Somewhat surprisingly, capitation by HMOs declined overall from 2009 to 2010, and only modestly increased among Article 43 nonprofit insurers. Independent Health Association reported the highest rate, but it is organized as an independent practice association (IPA) model HMO, which probably accounts for the high number. MVP Health Plan's rate is the highest among commercial HMOs. HIP's capitation rate (31.2 percent) comes as no surprise, given its longstanding risk-sharing arrangement with Montefiore Medical Center and other providers. In 2010, HIP made over $458 million in capitation payments to the Montefiore IPA, Inc. alone.[28] Going forward, health plan capitation will be an important number to watch for an early sign that ACA payment reforms are taking root in New York, and migrating from the Medicare program to other markets.

One of the main thrusts of the ACA is to encourage payment methodologies that move away from traditional fee-for-service arrangements based on volume, and toward outcome-based reimbursement that provides financial incentives for providers to better manage care, control costs, and achieve better outcomes. Key initiatives designed to improve care management include Medicare Accountable Care Organizations (ACOs),[29] integrated provider systems that will enter into incentivized risk-sharing arrangements with CMS for Medicare patients, with program parameters that encourage them to sign up other private and public payers as well; and Patient-Centered Medical Homes (PCMHs), groups of primary care providers that receive enhanced reimbursement in exchange for better care coordination and improvements to the patient experience.

New York providers and policymakers have shown some early leadership in embracing

25 Anderson E. October 3, 2011. Hospital Merger Is Official. *Albany Times Union*. Available at http://www.timesunion.com/business/article/Hospital-merger-is-official-2200433.php (accessed July 23, 2012).

26 Hartocollis A. June 21, 2012. Hospital Systems' Merger Talk Collapse as New Suitor, Mount Sinai, Steps In. *New York Times*.

27 See, for example: O'Malley A, A Bond, and R Berenson. August 2011. *Rising Hospital Employment of Physicians: Better Quality, Higher Costs? Issue Brief: Findings from HSC, No 136*. Washington, D.C.: Center for Studying Health System Change; Summer L. March 2011. *Integration, Concentration, and Competition in the Provider Marketplace*. Washington, D.C.: AcademyHealth, with support from the U.S. Agency for Health Care Research and Quality; Robinson J. November 2011. *More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits*. Washington, D.C: National Institute for Health Care Management, Expert Voices in Health Care Policy; Robinson J. 2011. Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration. *Health Affairs* 30(7): 1265-1271; and Prepared Statement of Professor Thomas L. Greaney Before the Committee on the Judiciary, United States House of Representatives, Subcommittee on Intellectual Property, Competition and the Internet on "Health Care Consolidation and Competition After PPACA." May 18, 2012. Available at http://judiciary.house.gov/hearings/Hearings%202012/Greaney%2005182012.pdf (accessed July 23, 2012).

28 NY Supplement, Health Insurance Plan of Greater New York, Report #13-Part B: Statement of Operations (For the year Ending 2010).

29 Affordable Care Act, Section 3022.

these reforms, particularly in the PCMH area.[30] Montefiore leads a provider group selected as one of 32 national "Pioneer ACOs" in December 2012.[31] More recently, 14 additional groups of New York providers signed on as ACOs.[32] There are similar efforts underway in New York's Medicaid program to shift patients with complex medical conditions out of Medicaid fee-for-service and into care management organizations. Given these efforts, and new requirements that Qualified Health Plans report annually on how they are using payment incentives to improve quality,[33] the question of how New York regulates risk transfers[34] and ensures that risk-bearing entities are adequately capitalized will likely emerge as a key regulatory issue. The growth of ACOs in particular could fundamentally alter the relationship between insurers and providers, and may affect the market as well, since the ability to contract with large hospital-based ACOs for a broad range of services will allow health plans seeking to expand into a new service area to quickly gain a foothold.

Self-Funding

The percentage of New York private sector employees enrolled in self-insured plans typically fluctuates between 40 and 50 percent. In 2010, an estimated 44.4 percent of employees in New York were covered by self-funded plans,[35] a decline from both 2009 (48.5 percent) and 2008 (51.4 percent).[36] While a limited number of ACA provisions apply to both non-grandfathered fully insured and self-funded coverage (e.g., young adult coverage), most of its provisions apply only to fully insured coverage, small group coverage in particular.

The ability of small employers to shift to self-funded coverage, and avoid ACA requirements, may well be a real sleeper issue for ACA implementation; state and federal regulators have worried that a drain of small employers to self-funded plans could undermine the Exchange and non-Exchange markets for small groups. Federal regulators recently solicited information[37] on plan sponsors' purchase of stop-loss coverage, and specifically the "attachment point"—the level of medical expenses for an individual employee or the whole firm at which the insurance coverage kicks in. The solicitation notes, "It has been suggested that some small employers with healthier employees may self-insure and purchase stop loss insurance policies with relatively low attachment points to avoid being subject to these requirements while exposing themselves to little risk. This practice, if widespread, could worsen the risk pool and increase premiums in the fully insured small group market, including in

30 Burke G. November 2011. *The Patient-Centered Medical Home: Taking a Model to Scale in New York.* New York: United Hospital Fund.

31 Pioneer Accountable Care Organization Model: General Fact Sheet. May 22, 2012. Center for Medicaid & Medicare Innovation. Available at http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf (accessed July 23,

32 Burke G. July 25, 2012. "Trends and Changes in New York's Health Care Delivery System and Payments Systems: Implications for CON and Health Planning." Presentation to the Planning Committee of the Public Health and Health Planning

33 Affordable Care Act, Section 1311(g).

34 New York State Department of Financial Services, Regulation 164, 11 NYCRR 101.

35 Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends. 2010 Medical Expenditure Panel Survey—Insurance Component, Table II.B.2b.(1)(2010).

36 Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends. 2009 Medical Expenditure Panel Survey—Insurance Component, Table V.B.2.b.(1)(2009).

37 Treasury, U.S. Department of Labor, HHS/CMS Request for Information Regarding Stop Loss Insurance, Federal Register/ Vol. 77, No. 84, Tuesday, May 1, 2012/Notices. Available at https://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=26054 (accessed July 31, 2012).

the Small Business Health Options Program (SHOP) Exchanges that begin in 2014." New York devised a creative way to enforce minimum attachment points for stop-loss coverage that blends the regulation of stop-loss insurers with other regulatory tools,[38] but its current standards for attachment points are lower than those recommended by the NAIC.[39]

Commercial Markets

As the sole source for individual subsidies and small business tax credits, the Exchange itself will become a new market for individuals and small groups in addition to its role as a new market organizer. It will operate alongside and in competition with existing markets, which the ACA preserves. Finding the right balance between the two market segments and guarding against selection is the overarching regulatory challenge for the commercial market,[40] and the subject of an upcoming state study.[41] But there are a number of other policy matters, discretionary decisions and regulatory issues that demand attention as well.

Old Markets and New Markets

According to a recent state-commissioned report (the "Urban Study"),[42] the ACA will rejuvenate the individual market in a number of ways. Taken together, premium and cost-sharing subsidies estimated at $2.4 billion annually, eased enrollment, more benefit and cost-sharing options, and the individual responsibility provisions will add an estimated 557,000 individuals to the Exchange market and another approximately 270,000 to the non-Exchange market for individuals, under a non-merged market scenario. The infusion of this significant enrollment should certainly stem the adverse selection problems that have long plagued this market. The Urban Study also predicts similar salutary effects for New York's small group market under the ACA, including lower premiums. In the same scenario analyzed, small group enrollment in the Exchange would reach 432,000 members, with small employers taking advantage of the enhanced small business tax credit to the tune of $217 million.

Newly invigorated individual and small group markets, however, still leave policymakers with a number of pressing decisions. On the individual market side, these decisions include whether to continue to require HMOs to offer the two standardized individual HMO packages,[43] and whether to appropriate the annual $39 million stop-loss subsidy.[44] This decision also has implications for the state's selection of a benchmark option that will be the basis for the essential health benefits (EHBs) required in individual and small group policies sold inside and outside of the Exchange.[45] In addition, plans must be made to transition over 3,400 individuals

38 Newell P and A Baumgarten. October 2009. *The Big Picture: Private and Public Health Insurance Markets in New York*. New York: United Hospital Fund.

39 National Association of Insurance Commissioners. Stop Loss Insurance Model Act. Volume/model 1-92-1.

40 Jost TS. September 2010. *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*. Washington, D.C.: The Commonwealth Fund.

41 Arnold J, T Oechsner, and D Holahan. December 6, 2011. "Health Insurance Exchange Planning: Status Report and Preliminary Modeling Results." Presentation for the United Hospital Fund and New York Health Foundation Roundtable, "The Affordable Care Act and New York's Insurance Markets: Defining the Role for a Health Benefit Exchange."

42 Blavin F, L Blumberg, M Buettgens, and J Roth. March 2012. *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*. Washington, D.C.: Urban Institute, Health Policy Center.

43 New York Insurance Law, Section 4321.

44 Aid to Localities Budget, FY2012-2013.S6245-E/A9053-E. Page 501. Available at http://publications.budget.ny.gov/budgetFP/enacted1213.html (accessed July 24, 2012).

45 Newell P. May 2012. *Defining Essential Health Benefits: Federal Guidance and New York Options*. New York: United Hospital Fund.

now insured through New York's Bridge Plan, the Pre-existing Condition Insurance Plan established by the ACA and underwritten by EmblemHealth.

On the small group side, one matter requiring attention is current statutory provisions allowing sole proprietors to purchase small group coverage under certain circumstances;[46] under ACA rules,[47] they are not permitted to purchase through the Exchange as a small group. New York also has the discretion to move up the 2016 deadline for incorporating employer groups with 51-100 employees in the small group market, and to merge the small group market and the individual markets.[48] Finally, while the ACA requires the Exchange to increase options available to employees beyond a single health plan when employers purchase there,[49] the broader embrace of the so-called "employer choice" or "defined contribution" models would make the small group market very much like the individual market, since employees could choose from any product offered through the Exchange by any participating health plan, altering the dynamics of selling group coverage for health plans.

A number of decisions are also queued up for the Healthy NY program, the public-private hybrid that includes all three market segments—individuals (84,933 members) and sole proprietors (22,085 members) earning 250 percent or less of the federal poverty level (FPL), and employees at lower-wage small businesses (57,687 members)[50]—and is subsidized through an annual $161 million reinsurance program.[51] The decision on the individual and sole proprietor populations is fairly straightforward: will coverage be more affordable through the Exchange, with a tax credit that caps premiums at 4 to 8.05 percent of income for individuals earning 150 percent to 250 percent of FPL, or through Healthy NY, with premiums reflecting a roughly 30 percent state subsidy? Based on 2012 federal poverty guidelines, an individual at the highest level of Healthy NY eligibility would pay a $187 monthly premium; the current (July 2012) premium for a traditional Healthy NY policy with prescription drug coverage in Albany County ranges from $320 to $380 per month.[52]

The analysis for Healthy NY small business members is more difficult. While a current small business premium tax credit available under the ACA will be expanded from 35 percent to 50 percent in 2014,[53] its eligibility standards differ from those of Healthy NY. Under the ACA, small businesses with up to 25 full-time equivalent employees that pay average annual wages of less than $50,000 are eligible for the credit.[54] Healthy NY is open to businesses with up to 50 employees, and small firms are eligible if at least 30 percent

46 New York Insurance Law, Section 4317(f).

47 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Final Rule, Interim Final Rule. March 27, 2012. U.S. Department of Health and Human Services. 45 CFR Parts 155, 156, and 157, Section 155.710.

48 Newell P and B Gorman. September 2011. *Two Into One: Merging Markets and Exchanges under the Affordable Care Act.* New York, United Hospital Fund.

49 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers. Final rule, Interim final rule. March 27, 2012. U.S. Department of Health and Human Services. 45 CFR Parts 155, 156, and 157, Section 155.705.

50 Burns & Associates. December 2010. Independent Report on the Healthy NY Program for Calendar Year 2010. Available at http://www.dfs.ny.gov/healthyny/reports/hny2010rep.pdf (accessed July 24, 2012).

51 Aid to Localities Budget, FY2012-2013.S6245-E/A9053-E.

52 New York State Department of Financial Services. Healthy NY insurers and rates, individual and sole proprietor coverage. Available at http://www.dfs.ny.gov/healthyny/hny_rates.htm (accessed July 31, 2012).

53 Affordable Care Act, Section 1421.

54 Internal Revenue Service, Small Business Health Care Tax Credit for Small Employers, Available at http://www.irs.gov/newsroom/article/0,,id=223666,00.html (accessed July 31, 2012).

of employees earn $40,000 or less. These eligibility differences in firm size and wage calculations mean that should the Healthy NY small group program lapse, some businesses will not be eligible to offset that loss with federal premium tax credits. The DFS's suspension of all enrollment save for the high-deductible health plan health savings accounts, beginning on January 1, 2012, suggests that tight state finances could also tip the balances toward winding down the program.[55]

Health Plan Market Participation

Over the past few years, enrollment in public markets has increased, commercial membership has declined, and consolidation has left fewer health plans offering coverage in both markets (though new plans regularly step up to the plate for swings at Medicare Advantage business). At least three new health plans seem likely to enter the Exchange market at some point, however. The U.S. Department of Health and Human Services (HHS) recently awarded a Consumer Operated and Oriented Plan (CO-OP) grant to Freelancers Union,[56] the sponsor of Freelancers Insurance Company, the Article 42 insurer that reported enrollment of over 22,000 individuals in its association plan in 2010 (Table 2). In its successful application, Freelancers projected that its new CO-OP, aided with $174 million in federal loan support, will cover 100,000 members within a seven-year period.

Other potential Exchange market entrants could be the two "multi-state plans"[57] to be selected by the federal Office of Personnel Management (OPM), one required to be a nonprofit plan, and the second a plan that does not cover abortion services. Supporting documents for the OPM's 2014 budget request include its intention to "enter into contracts with at least two issuers to offer Multi-State Plans on Affordable Insurance Exchanges by September 2013."[58] Although the OPM is not required to select multi-state plans for all 50 states by the time exchanges open for business, its implementation of the program is worth watching carefully, since the plans will operate alongside Exchange-certified Qualified Health Plans, but will be overseen by the OPM and exempt from some Exchange requirements.[59]

For existing plans, the possibility of one million new customers is a powerful incentive to participate, but a number of state discretionary and regulatory decisions will affect plan participation. New York will need to review current rules for HMOs, for example, since limitations on allowable cost sharing might leave them unable to offer higher cost-sharing designs required by the ACA—the catastrophic, bronze, and silver value actuarial plans. There are also a handful of issues with PHSP participation in the Exchange. Most of these plans have not been independently accredited as required by the ACA,[60] although New York has some flexibility as to when the accreditation must take place. PHSPs also

55 New York State Department of Financial Services. October 26, 2011. Healthy NY Frequently Asked Questions (FAQs). Available at http://www.dfs.ny.gov/healthyny/pdf_mix/hny_suspension_faqs_102011.pdf (accessed July 24, 2012).

56 Department of Financial Services. "New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers." Available at http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html (accessed June 20, 2012).; Freelancers Union. "CO-OP FAQs." Available at https://fu-res.org/pdfs/co-ops/CO-OP-FAQs.pdf (accessed June 20, 2012). Freelancers Union affiliates also received funding for CO-OPs in New Jersey and Oregon.

57 Affordable Care Act, Section 1334.

58 FY 2013 Budget Request from the U.S. Office of Personnel Management. February 2012. Available at http://www.opm.gov/budget/2013/2013budget.pdf (accessed July 24, 2012).

59 Riley T and J Thorpe. April 2012. *Multi-State Plans Under the Affordable Care Act.* Washington, D.C.: The George Washington University Medical Center, Department of Health Policy, with support from the Commonwealth Fund.

60 Affordable Care Act, Section 1311(c)(1)(D).

operate under state regulatory constraints that limit their non-public enrollment.

But no decision will be more important to determining health plan participation than the model New York selects for certifying the Qualified Health Plans eligible to offer coverage,[61] which runs the spectrum from allowing any licensed health plan meeting ACA standards to participate, to establishing a competitive bidding process and selecting a limited number of plans.

A recent grant application by New York for continued Exchange funding[62] provides a glimpse at the State's intentions, describing ongoing analysis of federal criteria for Qualified Health Plan eligibility as well as additional "state-specific criteria," all with the goal of issuing a solicitation to health plans in January 2013. Another element that might factor into health plans' decisions to participate in both the Exchange and non-Exchange markets is ongoing implementation of a new state-federal system for rate regulation.

Rate Review

New rules for commercial health plan rate review were launched in the fourth quarter of 2010 under New York's prior approval law,[63] and the ACA added a federal component to the process.[64] Because of an HHS determination that New York's prior approval law constitutes an "effective rate review program," the DFS remains the primary regulator and New York standards exceeding new federal requirements remain in effect. While the new joint state-federal system changes the game for health plans, calculations of their medical loss ratios are still at the core of regulation.

Table 13 presents medical loss ratios for three categories of commercial plans by line of business. This analysis relies on the traditional calculation of MLR dividing total medical expenses by total premiums to arrive at a percentage of revenues paid for medical expenses, across each line of business. Although results vary by plan, in 2010 HMOs on average paid out a lower percentage of large group and small group premiums for medical expenses, and a higher percentage for their individual and Healthy NY business, than they did in 2009. Article 43s, on the other hand, paid out a lower percentage of premiums toward medical expenses in major lines except for small group coverage. Article 42 insurers, subject to less detailed reporting requirements, showed lower individual and group MLRs in 2010 than in 2009.

The basis for this MLR analysis differs from the joint state-federal process in two important ways, as mapped out in regulatory guidance issued by the DFS in 2011.[65] State regulators describe a two-step process going forward, the "front end" and the "back end." For rate change applications of any sort (the front end), the DFS will continue to use the traditional claims-over-premiums method for MLR to see how proposed changes measure up against an 82 percent minimum MLR for community-rated policy forms, or groups of similar forms. In a separate process, federal regulators on the back end will review actual claims experience—not on the basis of policy forms, but for three lines of business

61 Newell P and RL Carey. December 2011. *Passive/Active: Defining the Role for a Health Benefit Exchange in the Interests of New Yorkers*. New York: United Hospital Fund.

62 New York State Exchange Establishment Level I Funding. June 29, 2012. Available at http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/project_narrative_level1_funding.pdf (accessed July 24,

63 NYS Chapter 107 of the Laws of 2010.

64 Public Health Service Act, Sections 2718 and 2794.

65 New York State Department of Financial Services. December 22, 2011. Insurance Circular Letter No. 15. Available at http://www.dfs.ny.gov/insurance/circltr/2011/cl2011_15.pdf (accessed July 24, 2012).

(individual, small group, and large group)—and will have the authority to direct health plans to provide rebates to customers when the 82 percent MLR target is not achieved for individual and small group business, and an 85 percent payout is not achieved for large group business. In addition to using the three market segments as the basis for their review, federal regulators will diverge from current state practice and allow plans "credit" for expenses related to taxes and regulatory fees and "expenses to improve health care quality." Finally, the federal MLR formula allows for reductions to the required rebate if it is derived from a smaller book of business, in which big swings in MLRs are possible.

The DFS estimates that, for rate changes taking effect January 1, 2012, it reduced average increases from 11.9 to 7.6 percent.[66] With the first batch of ACA rebates scheduled to be mailed out on August 1, 2012, federal regulators estimated that 83,541 individuals in New York would receive over $6 million in rebates, small groups $3.7 million, and another $76.8 million would be earmarked for large group policyholders in New York.[67]

An important byproduct of the new system is the extraordinary degree of transparency in an area that a short time ago was a closely guarded secret. Detailed information on proposed rate changes is now available on the DFS website[68], and, for individual and small group rate increase requests exceeding 10 percent, from HHS.[69]

This greater scrutiny of rate increases could result in more affordable products for individual and small business consumers, reductions in insurers' bottom lines, and perhaps reduced reimbursement for providers. Looking ahead, Exchange subsidies for commercial coverage blur the distinction between public and private markets, and add a nuance to the traditional arguments about the proper level of commercial market oversight. Historically, the Medicaid Managed Care program, reflecting the public investment in premiums, has been more tightly regulated. For example, as part of the Medicaid Redesign Team (MRT) process and the subsequent state budget for Fiscal Year 2011-2012, policymakers reduced the profit component in MMC plan rates from 3 percent to 1 percent and eliminated the marketing component from rates.[70] State regulators now balancing their core function as solvency protector and the obligation to alter rate increases that are unreasonable, inadequate, excessive, or discriminatory, will, unless an alternate approach is chosen, also need to consider the impact that rate reviews will have on health plans' willingness to offer coverage through the Exchange, since participation by Article 42 and Article 43 insurers is voluntary.

Benefits

While the health plans that will be offering coverage through the Exchange will not be known for some time, details on the essential health benefits required in all individual and small group coverage should be coming soon. The "benchmark option" process HHS

66 New York State Department of Financial Services. Summary of Actions on Health Insurance Premium Requests for 2012. Available at https://myportal.dfs.ny.gov/web/prior-approval/summary-of-actions-premium-requests (accessed July 24, 2012).

67 U.S. Department of Health and Human Services. The 80/20 Rule: Providing Value and Rebates to Millions of Consumers. Available at http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html (accessed July 24, 2012).

68 New York State Department of Financial Services. Rate Applications by Company. Available at https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company (accessed July 31, 2012).

69 Available at U.S. Department of Health and Human Services. New York Rate Reviews. Available at http://companyprofiles.healthcare.gov/states/NY/rate_reviews?search_method=rate_reviews (accessed July 31, 2012).

70 New York State Department of Health. Phase 1 MRT Proposals Project Management Plan (as of 4/10/12); Completed, Merged, Cancelled Projects. (See MRT #6 and MRT #10.) Available at http://www.health.ny.gov/health_care/medicaid/redesign/ (accessed July 30, 2012).

launched to define essential health benefits[71] requires New York to select one of 10 popular products as the basis for its benefits by the end of September 2012. Although the benchmark option selected by New York will have to be supplemented to capture some atypical benefits such as habilitative care, the core of the required benefits is common in New York coverage. One ACA-required benefit not currently prevalent is pediatric oral health care.

New York ranks slightly above average among states in terms of access to dental care[72] and the state certainly has the infrastructure to support the expansion. The DFS regulates a number of "dental only" Article 42 and 43 insurers, such Delta Dental Insurance Company and HealthPlex Insurance Company (DentCare Delivery Systems, Inc.). Delta reported nearly 400,000 enrolled members and about $133 million in premiums written in 2010, and HealthPlex reported enrollment of over 264,000 members and premiums of over $47 million. In addition to providing fully insured coverage, entities like HealthPlex often manage the benefits on behalf of insurers or self-funded plans, accepting capitation arrangements from health plans, and arranging services through an independent practice association. Full-service health insurers, including Excellus BCBS (202,133 dental members in 2010), Empire BCBS (84,690), and GHI (406,677), are also active in the market.

The ACA makes pediatric dental health care an EHB required in all individual and small group coverage, and subject to market reforms that ban annual limits. But plans offering stand-alone dental benefits through the Exchange separate from the EHB packages are not subject to the requirements. This is just one reason that incorporating the benefit will be challenging; others include deciding on the benefit level, and coordinating coverage for families with employer-sponsored dental coverage or public coverage for their children. Though dental coverage is common in employer-sponsored plans, making it part of the core benefits for individuals is a big change.

Finally, while EHB standards and the "precious metal" actuarial value categories will bring a new degree of standardization to the small group market, a recent study[73] released by the state shows a large number of products with low enrollment, particularly upstate, suggesting that some standardization would ease decision-making for small employers.

Risk Adjustment

Regulation 146,[74] New York's pioneering risk-adjustment mechanism, has operated in fits and starts in the Medicare Supplement, individual, and small group markets since it was authorized in 1992;[75] it raised and distributed about $91.25 million in 2010 to health plans with higher than average high-cost claims, or about $74 million when the figure is adjusted to net out receiving plans' contributions to the risk pool.[76] Over 98 percent of the contributions came from

71 Newell P. May 2012. *Defining Essential Health Benefits: Federal Guidance and New York Options*. New York: United Hospital Fund. See also: Harris T and S Muller. August 2, 2012. "Essential Health Benefits Overview." Presentation at "Exchange Stakeholder Meeting: Milliman Study of Essential Health Benefits." Available at http://www.healthcarereform.ny.gov/timeline/; related exhibits available at http://www.healthcarereform.ny.gov/timeline/docs/2012-08-02_milliman_exhibit1_app_a.pdf (both accessed August 13, 2012).

72 Kaiser Commission on Medicaid and the Uninsured. June 2012. *Oral Health in the U.S: Key Facts*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

73 Wakely Consulting Group. June 2012. *Benefit Standardization Study for the State of New York*. Boston: Wakely Consulting Group.

74 11 NYCRR 361.

75 Newell P and A Baumgarten. October 2009. *The Big Picture: Private and Public Health Insurance Markets in New York.* New York: United Hospital Fund. See Appendix I.

76 Personal communication, Department of Financial Services. February 2, 2012.

assessments raised from small group coverage, but two-thirds of the payments helped bring down rates for the dwindling number of individual customers, and one-third for small group rates. Empire BCBS HMO and Oxford Health Plans HMO, the two largest carriers in the standardized direct pay market, reported $16.8 million and $11.3 million in Reg. 146 pool recoveries in 2010.[77] The ACA includes requirements for temporary risk corridor and reinsurance programs and one permanent risk-adjustment mechanism,[78] however, which will likely close the books on Reg. 146.

Citing New York's experience in risk adjustment and reinsurance, the risk-adjusted rates administered by the DOH using Clinical Risk Groups, and the state's incipient All Payer Database,[79] a consultant hired to assist the state recommended that New York take an active role in both the reinsur-ance program and the new risk-adjustment mechanism.[80] The new reinsurance program, funded nationally through assessments on fully insured and self-funded payers, is similar to New York's existing stop-loss reinsurance program for the standardized individual market and Healthy NY,[81] but it could drive an estimated $600 million to offset the high-cost claims in New York's individual market in its first year—a far cry from current subsidy levels—though much smaller amounts in the remaining two years of the program. The permanent risk-adjustment program will ultimately be based on clinical measures of the risk of health plans' enrollees (ironically, resembling a version of Reg. 146 that was developed but not implemented, known as the "Fourth Amendment to Regulation 146") instead of high-cost claims, will be statewide rather than regionally administered, and will not cap the annual amount assessed and distributed. Unless New York merges its individual and small group markets, it is likely that the new mechanism will be administered through separate pools.

The risk-adjustment report outlines a number of complex decisions needed to implement the new systems to be made within tight time frames, though deferring to federal administration remains an option. Since health plans will find it difficult to develop premiums for products without the ability to project the impact of the risk-adjustment and reinsurance mechanisms on the risk profiles of their insured populations, this is a critical imple-mentation task facing the state.

Public Programs

ACA provisions establishing a new Medicaid eligibility level of 138 percent of the FPL (133 percent of the FPL, with a 5 percent income disregard) have a limited impact on New York in terms of enrollment, since Medicaid/FHP eligibility standards already exceed this level. New York will have to decide whether to maintain FHP eligibility at 150 percent of the FPL for parents, or instead make subsidized Exchange coverage available. There is also a decision on defining the "benchmark-level" benefit standard for childless adults newly eligible for Medicaid coverage, known as the

77 New York Supplement to Annual Statements, Empire BCBS and Oxford Health Plans, Report #2, Statement of Revenue and Expenses.

78 Affordable Care Act, Section 1343; Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule. March 23, 2012. U.S. Department of Health and Human Services. 45 CFR Part 153.

79 New York Public Health Law, Section 2816.

80 Winkelman R and S Mehmud. June 2012. *Risk Adjustment and Reinsurance under the ACA: New York State Recommendations*. Clearwater, FL: Wakely Consulting for New York State, with support from the Robert Wood Johnson Foundation and the New York State Health Foundation.

81 New York State Department of Financial Services Regulation No. 171, 11 NYCRR 362.

"expansion population," the subject of another upcoming state evaluation.[82] Even with these comparatively minor changes to eligibility levels under the ACA, Medicaid enrollment in New York is estimated to grow by more than 500,000 when the ACA is fully implemented, according to the Urban Study, and New York will receive a higher federal matching rate for some new and existing enrollees.

ACA public program income eligibility changes have a lesser impact on New York's public markets compared to potential changes in many other states. Nonetheless, the combination of ACA reforms and New York's Medicaid Redesign Team process, rolled out by the Cuomo Administration during the Fiscal Year 2011-2012 budget cycle, have triggered a feverish remaking of the Medicaid program not seen since federal officials approved New York's waiver application for mandatory Medicaid Managed Care in 1997.

Guided by the principle of "Care Management for All,"[83] New York has launched an extraordinary effort to end fee-for-service Medicaid as we know it. Benefits "carved out" of the Medicaid Managed Care program, such as prescription drugs and mental health, have been carved back in; exemptions and exclusions for certain populations are being phased out; and new integrated care models are being developed or expanded for Medicaid recipients with mental illness[84] or long-term care needs,[85] and for New Yorkers dually eligible for Medicaid and Medicare.[86]

These efforts to manage care for these populations and coordinate better with Medicare coverage are not entirely new. New York Managed Long-Term Care plans enrolled over 32,000 members in 2010, and have grown since then. Medicaid Advantage/Plus plans enrolled over 7,000 members in 2010. But the scale and breakneck pace for implementing these reforms are striking. In many ways, the implementation issues and operational challenges for HMOs, Managed Long-Term Care Plans, and PHSPs exceed those in the new subsidized commercial market: both types of plans will enroll significant new membership, but public markets will serve enrollees with far more complex medical needs.

As is the case with the commercial market, existing and potential new public market decisions are in play because of ACA subsidy provisions that affect the future of the FHP Employer Buy-In program, and the new federal option of implementing a Basic Health Program (BHP) for eligible individuals with incomes between 138 and 200 percent of the FPL.

While about 30,000 New Yorkers were enrolled in the FHP Buy-In program in 2010, all of the enrollment came from one plan (Fidelis) and one union (SEIU 1199). Despite efforts to broaden the appeal of

82 Arnold J, T Oechsner, and D Holahan. December 6, 2011. "Health Insurance Exchange Planning: Status Report and Preliminary Modeling Results." Presentation for the United Hospital Fund and New York Health Foundation Roundtable, "The Affordable Care Act and New York's Insurance Markets: Defining the Role for a Health Benefit Exchange."

83 New York State Department of Health. *A Plan to Transform the Empire State's Medicaid Program: Better Care, Better Health, Lower Costs. Multi-Year Action Plan*. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf (accessed July 24, 2012).

84 Patchias E and M Birnbaum. February 2012. *Implementing Behavioral Health Care Reform in New York's Medicaid Program.* New York: United Hospital Fund.

85 Samis S, A Detty, and M Birnbaum. February 2012. *Implementing Long-Term Care Reform in New York's Medicaid Program.* New York: United Hospital Fund.

86 New York State Department of Health's Demonstration to Integrate Care for Dual Eligible Individuals. Second Draft Proposal. Published for Public Comment on May 3, 2012. Available at http://www.health.ny.gov/facilities/long_term_care/dual_elig.htm (accessed July 24, 2012).

the program to more employer groups,[87] it occupies a niche serving selected unions with low-wage workers. Although Fidelis and SEIU 1199 ended their arrangement in 2011, the FY 2012-13 budget included funding[88] to cover unionized child care workers. The availability of federal subsidies for Exchange coverage may be a cause for reconsideration of the Buy-In program, but the biggest decision New York faces—and one affecting both public and private markets—is whether to establish a Basic Health Program option,[89] which would allow New York to draw down estimated Exchange subsidies for individuals between 138 percent to 200 percent of the FPL, and create an FHP-like program for these enrollees instead.

Many observers believe this approach would result in additional state savings, provide more affordable coverage for low-income individuals than the Exchange, and protect against tax liabilities if their income increases beyond allowable BHP levels during the year—and could reduce churning and promote better continuity of care, since fewer enrollees would bounce back and forth between Exchange coverage and Medicaid.[90] On the other hand, some worry about this option's resemblance to a block grant program, the financing for the BHP is still uncertain, the regulations have not been issued, and enrollees would probably not have access to the same provider networks as in the Exchange. Finally, estimated enrollment of 468,000 in the BHP[91] would reduce the clout the Exchange could bring to bear in the commercial market, and dilute its risk pools somewhat.

Resources

The scale and number of tasks facing New York policymakers in the simultaneous remaking of public and private markets are daunting; fortunately, New York has a willing partner in Washington, which has put significant resources on the table. While premium and cost-sharing subsidies for Exchange coverage will not begin to flow until 2014, New York State has already benefited from an estimated $1.05 billion in new federal resources due to the ACA, for a wide variety of public and private purposes. According to a recent estimate,[92] over $779 million in funding has gone to private recipients, and about $273 million to governmental entities.

State grants have been devoted to such tasks as planning and staffing the Exchange, designing and building the complex information technology systems required, establishing the All Payer Database, and ramping up the statewide consumer assistance programs. The ACA's Health Home provisions[93] and higher Medicaid matching rate, and support from CMS's Medicare-Medicaid Coordination and Center for Medicare & Medicaid Innovation are helping underwrite the MRT reforms.

87 Benjamin ER and A Garza. June 2010. *Expanding Affordable Coverage for Low-Waged Workers. Fixing the Family Health Plus Employer Buy-In*. New York: Community Service Society.

88 Aid to Localities Budget, FY2012-2013. S6245-E/A9053-E. Available at http://publications.budget.ny.gov/budgetFP/enacted1213.html (accessed July 24, 2012).

89 Affordable Care Act, Section 1311.

90 Benjamin ER and A Slagle. June 2011. *Bridging the Gap: Exploring the Basic Health Insurance Option for New York*. New York: Community Service Society; Dorn S, M Buettgens, and C Carroll. September 2011. *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States*. Washington, D.C.: Urban Institute, Health Policy Center.

91 Blavin F, L Blumberg, M Buettgens, and J Roth. March 2012. *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*. Washington, D.C.: Urban Institute, Health Policy Center. This study concludes that when individual and small group enrollment in the Exchange are combined, it will still be large enough to be "viable and stable," despite the loss of BHP enrollees.

92 The Henry J. Kaiser Family Foundation. ACA Federal Funds Tracker. Health Reform Source. Available at http://healthreform.kff.org/federal-funds-tracker.aspx?source=QL# (accessed July 5, 2012).

93 Affordable Care Act, Section 2703.

Private funding has supported early-retiree reinsurance programs for large public and private employers, grants to strengthen health centers, and a wide array of efforts to improve the health care delivery system.[94]

Should New York be successful in its recently announced bid for a long-term federal Medicaid waiver amendment,[95] the funding available to revamp New York's Medicaid program and health care delivery system would increase dramatically, as the State is seeking to claim up to $10 billion over the next five years from the $17.1 billion in savings it projects over the same period.[96]

Conclusion

When the ACA was enacted, some New Yorkers voiced disappointment at certain elements of the final agreement—the federal Medicaid matching rate for states such as New York that "did the right thing" by expanding Medicaid eligibility, the drop in subsidies for people earning between 300 and 400 percent of the FPL between the House and Senate bills, and cuts to hospital indigent care funding coupled with restrictions on non-citizens' access to affordability subsidies and the Exchange. Even when the ACA is fully implemented, estimates are that 1.7 million New Yorkers will still lack coverage.[97] But viewed in the context of this market analysis, and noting the surge of activity that has already taken place, the ACA seems a promising prescription for New York's ailing health care system.

The Exchange, affordability credits for individuals and small business, reinsurance funding, and the individual mandate will make New York's dysfunctional individual market a distant memory, and should bolster small employer participation as well. Enhanced federal matching rates will provide an estimated $2 billion in Medicaid savings for New York,[98] with the prospect of additional state funding through the waiver process and continuing support of the MRT effort. Through newly created entities like the Center for Medicaid & Medicare Innovation, significant federal resources are being brought to bear across the state to support the most thoughtful and promising ideas on improving quality and restraining costs.

We have often noted the dual nature of public and private insurance market regulation in New York, and the differences in licenses, products, networks, and financing. One striking element of reform is the number of ways the two markets are now dovetailing, and how it will be much more difficult for policymakers to sidestep the differences going forward.

Changes in commercial rate review rules and EHB provisions make commercial products a little more like public ones, and the ongoing state efforts to manage the care of Medicaid recipients (and the federal government's efforts toward Medicare recipients) have resulted in plan structures and benefit packages more like those in the

94 For details in New York funding under the ACA, see http://www.healthcarereform.ny.gov/grants/; and *How the Health Care Law is Making a Difference for the People of the State of New York*, a HealthCare.gov summary available at http://www.healthcare.gov/law/resources/ny.html (both accessed July 31, 2012).

95 Governor Andrew M. Cuomo. Press release, June 4, 2012. "Governor Cuomo Announces that New York Will Request a Federal Waiver to Invest $10 Billion in Medicaid Redesign Team Savings to Transform the State's Health Care System." Available at http://www.governor.ny.gov/press/06042012-new-federal-waiver-to-request (accessed July 24, 2012).

96 New York State Department of Health. *New York State Medicaid Redesign Team (MRT) Waiver Amendment. Achieving the Triple Aim*. Available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf (accessed August 13, 2012).

97 Blavin F, L Blumberg, M Buettgens, and J Roth. March 2012. *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*. Washington, D.C.: Urban Institute, Health Policy Center.

98 Blavin F, L Blumberg, and M Buettgens. March 2012. *Estimated New York State Medicaid Savings Under the Patient Protection and Affordable Care Act (ACA)*. Washington, D.C.: Urban Institute, Health Policy Center.

commercial market. Commercial health plan networks for all licensees—not just HMOs—will be vetted for adequacy within the Exchange, perhaps using the same system in place for MMC plans, or the ACA accreditation process. Exchange plans will also have to contract with "essential community providers," and many agree that better alignment between commercial networks and public program networks is necessary to ensure continuity of care and quality as individuals shift between Medicaid and the Exchange. New York's All Payer Database will aggregate claims data from most payers, even self-funded plans. Accountable Care Organizations and Patient-Centered Medical Homes—bringing Medicare, Medicaid, commercial insurers, public employers, and Taft-Hartley trusts together—will make it harder to reconcile reimbursement differences.

Certainly, in the form of the November elections and the debate on expiring tax breaks and deficit reduction coming at the end of 2012, there is uncertainty ahead. And the sheer magnitude of tasks required means that state officials, providers, consumer advocates, and health plan operatives are losing sleep at night (or fending off bad dreams). But these are heady times for New York's health care system.

Tables

Table 1. **New York Health Plan Revenue and Net Income, 2010**

Article 44 HMOs	Underwriting Revenue	Underwriting Net Income	Investment Income	Income Taxes	Net Income (Loss)	Margin	Net Income (Loss) Per Member Per Month
Aetna Health	$702,832,009	$53,446,875	$14,732,958	$17,807,175	$50,078,558	7.1%	$41.38
Arcadian Health Plan	10,993,737	(847,682)	83	0	(847,599)	-7.7%	(59.05)
Atlantis Health Plan	112,804,255	(915,167)	2,655	0	(166,602)	-0.1%	(0.49)
CDPHP	1,018,425,425	33,765,811	9,217,543	0	42,983,654	4.2%	15.61
Catholic Special Needs Plan	28,244,994	1,527,127	22,391	0	1,549,518	5.5%	157.76
CIGNA HealthCare*	5,709	157,542	1,122,036	174,154	1,105,424	19362.8%	NA
ElderPlan	216,920,952	(6,185,412)	6,107,030	0	(78,382)	0.0%	(0.42)
Empire BCBS HMO	1,959,269,444	225,248,584	57,863,138	79,624,378	178,809,886	9.1%	49.40
Essence Healthcare	14,077,461	(1,930,621)	4,174	0	(1,926,447)	-13.7%	(103.43)
GHI HMO (EmblemHealth)	44,991,707	(4,608,921)	961,187	0	(3,531,738)	-7.8%	(35.20)
Health Net of NY (UnitedHealthcare)**	260, 257,273	(26,474,275)	582,239	(9,444,092)	(17,397,004)	-6.7%	(26.63)
Independent Health Association	1,087,076,156	56,157,295	12,967,099	(286,549)	70,155,972	6.5%	36.26
Managed Health (HealthFirst)	1,295,112,779	13,031,138	3,925,103	0	16,486,712	1.3%	15.01
MVP Health Plan	2,084,427,206	98,843,841	27,917,183	502,706	124,364,142	6.0%	32.60
Oxford Health Plan (UnitedHealthcare)***	2,045,160,151	157,144,491	17,366,109	61,553,362	112,881,083	7.2%	43.40
Quality Health Plans****	151,072	(506,400)	159,490	0	(346,910)	-229.6%	(1,752.07)
Senior Whole Health	21,105,465	(4,036,032)	1,238	0	(4,034,794)	-19.1%	(472.18)
Touchstone Health HMO	222,433,609	481,014	(190,257)	0	(4,684,324)	-2.1%	(23.63)
UnitedHealthcare HMO	975,312,317	95,301,506	9,803,254	35,632,330	69,392,278	7.1%	21.75
Article 44 Subtotal	12,099,601,721	689,600,714	162,564,653	185,563,464	634,793,427	5.2%	28.10

Article 43 Nonprofit Insurers	Underwriting Revenue	Underwriting Net Income	Investment Income	Income Taxes	Net Income (Loss)	Margin	Net Income (Loss) Per Member Per Month
CDPHP Universal Benefits	334,088,000	1,483,272	850,668	0	2,333,940	0.7%	2.49
Excellus BCBS	5,172,151,053	32,970,703	68,563,755	24,083,701	44,450,757	0.9%	2.42
Group Health Inc. (EmblemHealth)	3,594,070,501	(57,922,016)	18,068,248	(8,993,426)	(32,673,230)	-0.9%	(1.57)
HIP (EmblemHealth)	4,905,865,515	212,476,542	27,864,006	1,326	239,686,390	4.9%	24.39
HealthNow BCBS	2,397,110,784	26,422,535	37,269,242	11,398,000	52,692,896	2.2%	8.78
Independent Health Benefits	477,937,156	3,157,392	1,624,784	1,781,228	3,033,322	0.6%	2.11
Preferred Assurance (MVP Health Care)	64,638,661	(4,326,978)	185,000	0	(4,141,978)	-6.4%	(16.12)
Article 43 Subtotal	16,945,861,670	214,261,450	154,425,703	28,270,829	305,382,097	1.8%	5.30

* CIGNA and WellCare Health Insurance of New York had no enrollees during 2010.

** Health Net consolidated with United Healthcare as of 2010.

*** During 2010 Oxford Health Plans received a dividend of $13,000,000 from Oxford Health Insurance, a wholly owned subsidiary. That amount has been eliminated in this table.

**** Quality Health Plans had only 13 members in its New York Medicare Advantage plan at the end of 2010.

Source: Authors' analysis of health insurer annual statements, Statement of Revenues and Expenses, and Medicaid Managed Care Operating Reports to New York State Department of Health.

Table 1. **New York Health Plan Revenue and Net Income, 2010** (cont.)

Article 42 Accident and Health Insurers	Underwriting Revenue	Underwriting Net Income	Investment Income	Income Taxes	Net Income (Loss)	Margin	Net Income (Loss) Per Member Per Month
Aetna Health Insurance Co. of NY	$8,815,248	$789,003	$382,623	$348,304	$542,922	6.2%	2.30
Empire BCBS	4,931,229,300	171,469,191	223,767,343	68,496,783	324,379,661	6.6%	14.17
Freelancers Insurance Co.	83,114,015	1,463,365	580,946	40,000	2,004,262	2.4%	7.65
Health Net Insurance of NY (UnitedHealthcare)	596,751,168	(68,135,643)	1,066,655	(24,528,625)	(42,993,963)	-7.2%	(30.15)
HIP Insurance Co. (EmblemHealth)	199,480,659	(14,486,616)	1,646,638	(5,946,044)	(7,049,725)	-3.5%	(6.65)
Humana Insurance Co. of NY	137,941,889	7,185,578	1,251,030	3,301,029	5,135,760	3.7%	8.40
MVP Health Insurance	696,296,742	(79,297,376)	4,024,504	0	(75,257,881)	-10.8%	(31.68)
Oxford Health Insurance (UnitedHealthcare)	2,416,926,969	182,149,931	15,912,129	68,199,396	129,903,836	5.4%	10.76
UnitedHealthcare Insurance Co.	1,613,641,790	96,471,947	32,718,539	39,149,407	89,722,526	5.6%	4.21
WellCare Health Insurance of NY*	113,557	2,430,270	43,754	769,886	1,704,138	1500.7%	NA
Article 42 Subtotal	10,684,311,337	300,039,650	281,394,161	149,830,136	428,091,536	4.0%	6.87
TOTAL (Article 42, 43, & 44)	39,729,774,728	1,203,901,814	598,384,517	363,664,429	1,368,267,060	3.4%	9.60

Prepaid Health Services Plan	Premium Revenue	Underwriting Net Income	Investment Income	Income Taxes	Net Income (Loss)	Margin	Net Income (Loss) Per Member Per Month
Affinity Health Plan	815,579,207	12,969,610	2,528,927	0	3,658,298	0.4%	1.17
Amerigroup	303,877,441	(6,405,559)	840,005	461,640	832,272	0.3%	0.63
HealthFirst	1,374,546,163	(5,526,587)	3,115,511	0	1,163,092	0.1%	0.21
HealthPlus	874,921,756	(12,040,057)	2,841,175	0	(2,426,639)	-0.3%	(0.67)
Hudson Health Plan	347,351,141	(2,439,662)	(6,069)	0	(7,050,123)	-2.0%	(5.85)
Liberty Health Advantage	52,429,250	(2,614,374)	(235,601)	16,028	(376,773)	-0.7%	(8.07)
MetroPlus	1,200,092,284	68,006,825	1,473,427	0	56,301,082	4.7%	11.93
Neighborhood Health Providers	628,851,912	(14,156,141)	4,198,740	0	(1,628,691)	-0.3%	(0.65)
NYS Catholic Health Plan (Fidelis Care)	1,902,776,094	8,609,754	9,559,794	0	61,846,038	3.3%	8.25
SCHC Total Care	116,946,281	(667,274)	116,324	0	(1,820,703)	-1.6%	(3.74)
Univera Community Health	129,542,843	14,171,455	17,135	0	6,062,142	4.7%	11.12
WellCare	490,746,988	18,770,453	743,129	10,764,314	18,725,723	3.8%	15.07
PHSP Total	8,237,661,360	78,678,443	25,192,497	11,241,982	135,285,718	1.6%	4.24

* CIGNA and WellCare Health Insurance of New York had no enrollees during 2010.

Source: Authors' analysis of health insurer annual statements, Statement of Revenues and Expenses, and Medicaid Managed Care Operating Reports to New York State Department of Health.

Table 2. **Enrollment in New York Health Insurance Plans, 2010 and 2009**

Article 44 HMOs	Direct Pay	Large Group	Small Group	Healthy NY	Medicare	Medicaid**	Child Health Plus	Family Health Plus	2010 TOTAL	2009 TOTAL
Aetna Health	3,020	69,409	4,424	5,968	15,106	NA	NA	NA	97,927	118,176
Arcadian Health Plan	NA	NA	NA	NA	1,456	NA	NA	NA	1,456	238
Atlantis Health Plan	104	5,202	16,315	4,943	NA	NA	NA	NA	26,564	27,488
CDPHP	355	93,764	21,001	9,310	21,304	57,244	18,727	5,438	227,143	241,086
Catholic Special Needs Plan	NA	NA	NA	NA	916	NA	NA	NA	916	580
CIGNA HealthCare	NA	NA	NA	NA	NA	NA	NA	NA	NA	9
Community Blue HMO (HealthNow BCBS)*	139	18,542	24,070	4,249	38,508	36,333	11,709	4,676	138,226	150,887
ConnectiCare (EmblemHealth)	8	NA	21	NA	NA	NA	NA	NA	29	28
ElderPlan	NA	NA	NA	NA	15,025	403	NA	NA	15,428	15,269
Empire BCBS HMO	7,682	50,368	49,092	48,089	61,130	NA	64,139	NA	280,500	333,131
Essence Healthcare	NA	NA	NA	NA	1,700	NA	NA	NA	1,700	NA
Excellus BCBS HMO*	870	44,942	7,985	12,874	54,975	109,551	48,748	16,503	296,448	314,713
GHI HMO (EmblemHealth)	21	6,078	316	1,095	NA	NA	NA	NA	7,510	28,802
HIP (EmblemHealth)*	4,051	383,551	22,879	3,603	124,543	217,831	14,405	29,468	800,331	854,449
Health Net of NY (UnitedHealthcare)	561	37,066	5,683	1,027	NA	NA	NA	NA	44,337	74,171
Independent Health Association	376	59,354	4,576	4,855	54,435	35,687	638	2,476	162,397	164,910
Managed Health (HealthFirst)	1	NA	NA	402	93,337	71	NA	NA	93,811	88,292
MVP Health Plan	210	127,912	14,649	12,425	94,341	31,399	2,365	3,164	286,465	355,246
Oxford Health Plan (UnitedHealthcare)	8,821	59,000	127,927	33,280	70,509	NA	NA	NA	299,537	268,158
Quality Health Plans	NA	NA	NA	NA	13	NA	NA	NA	13	NA
Senior Whole Health	NA	NA	NA	NA	NA	783	NA	NA	783	761
Touchstone Health HMO	NA	NA	NA	NA	15,570	1,242	NA	NA	16,812	14,216
UnitedHealthcare HMO	NA	NA	NA	NA	10,857	211,162	19,128	35,019	276,166	252,750
Total 2010	26,219	955,188	298,938	142,120	673,725	701,706	179,859	96,744	3,074,499	
Total 2009	32,714	1,181,322	336,160	135,218	662,763	682,490	176,062	96,631		3,303,360
2010 Line of Business %	0.9%	31.1%	9.7%	4.6%	21.9%	22.8%	5.9%	3.1%	100.0%	

* HMO line of business of Article 43 companies. Community Blue is the HMO of HealthNow New York.

** Includes Medicaid Managed Care, Medicaid Advantage, and Medicaid Advantage Plus.

Note: Aetna Health, Empire HealthChoice Assurance, HIP Insurance Company of New York, and MVP Health Insurance Co. report selling out-of-network benefits, which may result in double-counting of HMO and Accident and Health enrollees.
Source: Authors' analysis of health plan annual statements, New York State supplements. Dental- and vision-only enrollment not included.

Table 2. **Enrollment in New York Health Insurance Plans, 2010 and 2009** (cont.)

Article 43 Nonprofit Insurers	Provider Service Organizations	Preferred Provider Organizations	Point of Service	Indemnity Only	Other***	2010 TOTAL	2009 TOTAL
CDPHP Universal Benefits	NA	81,545	NA	NA	NA	81,545	64,127
Excellus BCBS	NA	582,723	106,766	531,201	19,320	1,240,010	1,211,172
Group Health Inc. (EmblemHealth)	NA	1,557,979	NA	NA	NA	1,557,979	1,540,256
HIP (EmblemHealth)	NA	NA	12,137	NA	1,913	14,050	28,443
HealthNow BCBS	NA	119,207	36,718	245,637	NA	401,562	437,893
Independent Health Benefits	5,553	13,381	92,947	1,669	NA	113,550	123,537
Preferred Assurance (MVP Health Care)	NA	15,689	2,210	NA	NA	17,899	35,226
Total 2010	5,553	2,370,524	250,778	778,507	21,233	3,426,595	
Total 2009	4,533	2,251,831	315,756	846,174	22,360		3,440,654
2010 Line of Business %	0.2%	69.2%	7. 3%	22.7%	0.6%	100.0%	

Article 42 Accident and Health Insurers	Individual Comprehensive	Small Group Comprehensive	Large Group Comprehensive	Health Savings Accounts	Medicare Supplement	Medicare Part D	Out of Network HMO/POS	Other	2010 TOTAL	2009 TOTAL
Aetna Health Insurance Co. of NY	NA	NA	NA	NA	NA	NA	17,983	NA	17,983	37,192
Empire BCBS	13,250	170,196	1,210,623	18,784	45,060	NA	24,607	31,377	1,513,897	2,448,006
Freelancers Insurance Co.	NA	NA	22,003	NA	NA	NA	NA	NA	22,003	21,582
Health Net Insurance of NY (UnitedHealthcare)	NA	39,638	17,183	NA	NA	7,474	NA	NA	64,295	176,615
HIP Insurance Co. (EmblemHealth)	NA	NA	NA	NA	NA	34,379	12,137	38,275	84,791	95,912
Humana Insurance Co. of NY	NA	NA	NA	NA	280	5,750	NA	43,274	49,304	52,558
MVP Health Insurance	NA	78,915	74,646	NA	NA	NA	13,997	NA	167,558	141,640
Oxford Health Insurance (UnitedHealthcare)	2,999	402,310	368,260	NA	NA	NA	NA	NA	773,569	771,793
UnitedHealthcare Insurance Co.	433	24,321	1,248,966	NA	245,178	224,818	NA	47,571	1,791,287	1,773,233
WellCare Health Insurance of NY	NA	NA	NA	NA	NA	NA	NA	NA	NA	4,760
Total 2010	16,682	715,380	2,941,681	18,784	290,518	272,421	68,724	160,497	4,484,687	
Total 2009	16,259	761,831	3,899,666	5,782	285,444	261,470	95,782	197,057		5,523,291
2010 Line of Business %	0.4%	16.0%	65.6%	0.4%	6.5%	6.1%	1.5%	3.6%	100.0%	

*** The 19,320 enrollees listed for Excellus were all in Medicare Part D. Of the 1,913 enrollees listed for HIP, 1,011 were in a Medicare Cost contract and 902 were in a dental-only plan.

Note: Aetna Health, Empire HealthChoice Assurance, HIP Insurance Company of New York, and MVP Health Insurance Co. report selling out-of-network benefits, which may result in double-counting of HMO and Accident and Health enrollees.
Source: Authors' analysis of health plan annual statements, New York State supplements. Dental- and vision-only enrollment not included.

Table 2. **Enrollment in New York Health Insurance Plans, 2010 and 2009** (cont.)

Prepaid Health Services Plan	Medicaid	Child Health Plus	Family Health	2010 TOTAL	2009 TOTAL
Affinity Health Plan	213,615	23,582	31,793	268,990	249,433
Amerigroup	81,469	8,774	16,860	107,103	112,459
HealthFirst	392,163	24,825	42,707	459,695	430,840
HealthPlus	247,451	28,238	33,669	309,358	294,370
Hudson Health Plan	71,087	22,544	10,014	103,645	88,128
MetroPlus	339,364	18,933	34,168	392,465	369,941
Neighborhood Health Providers	173,107	12,581	18,643	204,331	213,250
NYS Catholic Health Plan (Fidelis Care)	478,408	71,230	84,581	634,219	518,431
SCHC Total Care	34,427	4,113	3,789	42,329	37,924
Univera Community Health	33,088	7,207	6,252	46,547	43,846
WellCare	62,801	4,866	10,216	77,883	89,352
Total 2010	2,126,980	226,893	292,692	2,646,565	
Total 2009	1,954,141	219,844	273,989		2,447,974

Note: Aetna Health, Empire HealthChoice Assurance, HIP Insurance Company of New York, and MVP Health Insurance Co. report selling out-of-network benefits, which may result in double-counting of HMO and Accident and Health enrollees.

Source: Authors' analysis of health plan annual statements, New York State supplements. Dental- and vision-only enrollment not included.

Table 3. **Enrollment in Medicare Advantage Plans, January 2011 and January 2010**

Health Plan	2011 HMO	Local PPO	Regional PPO	Private FFS	HCPP/ Cost	PACE	2011 Total	2010 Total
Aetna Health/ Life Insurance	13,645	8,993					22,638	20,406
Affinity Health Plan	2,769						2,769	2,015
American Progressive (Universal American)		10,905		25,533			36,438	37,312
AmeriGroup	862						862	626
Anthem Insurance Companies				757			757	752
Arcadian Health Plan	1,556						1,556	619
Boro Medical Center							NA	1,005
CDPHP	20,914	5,083					25,997	24,404
Catholic Special Needs Plan	853						853	555
Comprehensive Care Management	209					2,054	2,263	2,158
CIGNA							NA	2,730
ElderPlan	13,327						13,327	15,267
EmblemHealth (GHI/HIP)	115,817	22,528			897		139,242	152,089
Empire BCBS	62,963	30,036					92,999	75,197
Essence Healthcare	1,972						1,972	453
Excellus BCBS	52,036	30,383			2,091		84,510	77,590
HealthNow BCBS	34,613	18,939					53,552	55,474
HealthPlus	1,668						1,668	524
Humana Insurance/HMO	175	1,195		677			2,047	5,234
Independent Health Association	56,918	3,715					60,633	56,238
Independent Living for Seniors						677	677	653
Liberty Health Advantage	3,918						3,918	3,304
Managed Health (HealthFirst)	91,427						91,427	87,061
MetroPlus	4,518						4,518	2,464
MVP Health Care	52,335	30,442					82,777	81,862
New York State Catholic Health Plan (Fidelis Care)	9,028						9,028	6,300
New York Hotel Trades Council					3,477		3,477	3,373
Oxford Health Plans/ UnitedHealthcare Insurance	81,845	996	28,477				111,318	100,459
Senior Whole Health	762						762	542
Touchstone Health HMO	16,835						16,835	15,064
VNS Choice	5,867						5,867	3,490
WellCare of New York/Florida	18,582						18,582	20,291
Other (<300)	604	107			67	281	1,059	658
2011 Total	666,018	163,322	28,477	26,967	6,532	3,012	894,328	
2010 Total	682,661	92,513	19,119	50,693	8,358	2,825		856,169

Notes: Enrollment in multiple plans with a common parent company is combined. For privacy reasons, CMS does not report data by health plan for counties in which a health plan has fewer than 10 enrollees.

Source: Authors' analysis of CMS State/County/Contract Medicare Advantage Monthly Enrollment Report, January 2011. Available online at http://www. cms. gov/MCRAdvPartDEnrolData/MMAESCC/list.asp#TopOfPage

Table 4. **Net Income (Underwriting) by Company and Line of Business, 2010**

Article 44 HMOs	Large Group	Small Group	Individual	Healthy New York	Medicare	Medicaid	Family/Child Health Plus	TOTAL*
Aetna Health	$36,703,822	($1,564,228)	$3,015,299	$1,128,012	$14,163,970	NA	NA	$53,446,875
Arcadian Health Plan	NA	NA	NA	NA	(847,682)	NA	NA	(847,682)
Atlantis Health Plan	1,369,195	(1,210,540)	286,432	(1,360,254)	NA	NA	NA	(915,167)
CDPHP	19,694,785	3,981,847	1,602,688	652,314	3,079,035	$4,065,188	$689,954	33,765,811
Catholic Special Needs Plan	NA	NA	NA	NA	1,527,127	NA	NA	1,527,127
CIGNA HealthCare	125,374	(128,632)	134,525	26,275	NA	NA	NA	157,542
ElderPlan	NA	NA	NA	NA	(5,355,287)	(835,166)	NA	(6,190,453)
Empire BCBS HMO	43,327,537	23,107,079	31,955,282	16,626,581	101, 836,608	NA	8,395,497	225,248,584
Essence Healthcare	NA	NA	NA	NA	(1,930,621)	NA	NA	(1,930,621)
GHI HMO (EmblemHealth)	(920,237)	(412,402)	(337,213)	(1,692,760)	NA	(304,896)	(941,413)	(4,608,921)
Health Net of NY (UnitedHealthcare)	(21,617,928)	(5,781,882)	2,065,694	(349,626)	(6,269)	NA	157,406	(26,474,275)
Independent Health Association	13,035,507	57,549	(695,364)	480,899	39, 855,299	2,821,821	601,584	56,157,295
Managed Health (HealthFirst)	NA	103	46	(28,193)	13,002,486	56,695	NA	13,031,137
MVP Health Plan	49,014,260	(4,213,053)	(1,823,875)	(215,449)	52,092,866	4,795,639	(806,546)	98,843,842
Oxford Health Plan (UnitedHealthcare)	32,905,433	53,275,205	9,311,400	(28,765,379)	90,417,832	NA	NA	157,144,491
Senior Whole Health	NA	NA	NA	NA	2,371	(4,038,403)	NA	(4,036,032)
Touchstone Health HMO	NA	NA	NA	NA	(1,363,356)	1,844,370	NA	481,014
UnitedHealthcare HMO	NA	NA	NA	NA	48,219,347	38,465,221	7,891,454	95,301,506
Article 44 Total	173,637,748	67,111,046	45,514,914	(13,497,580)	354,693,726	46,870,469	15,987,936	690,102,073

Article 43 Nonprofit Insurers	Large Group	Small Group	Individual	Experience-Rated Groups	TOTAL
CDPHP Universal Benefits	NA	3,713,336	(5,686,755)	3,456,691	1,483,272
Excellus BCBS	38,838,233	(8,676,631)	7,522,805	(4,713,707)	32,970,700
Group Health Inc. (EmblemHealth)	NA	(93,511,228)	37,865,953	(2,276,741)	(57,922,016)
HIP (EmblemHealth)	213,783,328	NA	(1,306,786)	NA	212,476,542
HealthNow BCBS	2,494,019	(26,871,810)	5,665,199	45,135,127	26,422,535
Independent Health Benefits	NA	(2,592,396)	(3,554,375)	9,304,163	3,157,392
MVP Health Services	NA	NA	NA	628,646	628,646
Preferred Assurance (MVP Health Care)	(1,579,853)	(1,136,244)	NA	(1,610,881)	(4,326,978)
Article 43 Total	253,535,727	(129,074,973)	40,506,041	49,923,298	214,890,093

* Total column includes results from other lines of business for Health Net and UnitedHealthcare HMO. Health Net reports ($784,264) net underwriting income from other lines of business, and UnitedHealthcare HMO reports $611,911 net underwriting income from other lines of business.

Notes: Based on underwriting revenues and expenses, not including investment income or income taxes and not including results on dental or vision plans. Because of revenue, net income, or losses that are not reflected in the categories summarized in this table, data in rows for individual health plans may not equal the totals reported for those plans.

Source: Authors' analysis of annual statements for health plans. For HMOs and Article 43 nonprofit insurers, New York State supplement reports. For Accident and Health companies, NAIC page 7. For PHSPs, annual Medicaid Managed Care Operating Reports, Department of Health.

Table 4. **Net Income (Underwriting) by Company and Line of Business, 2010** (cont.)

Article 42 Accident and Health Insurers	Comprehensive	Medicare Supplement	Federal Employees	Medicare	Other Health	TOTAL
Aetna Health Insurance Co. of NY	$789,003	NA	NA	NA	NA	$789,003
Empire BCBS	126,794,702	23,689,306	(17,890,476)	6,860,535	25,106,920	164,560,987
Freelancers Insurance Co.	1,463,365	NA	NA	NA	NA	1,463,365
Health Net Insurance of NY (UnitedHealthcare)	(68,218,237)	NA	NA	764,333	(681,739)	(68,135,643)
HIP Insurance Co. (EmblemHealth)	(9,582,490)	NA	NA	50,349	(4,954,475)	(14,486,616)
Humana Insurance Co. of NY	NA	(10,364)	NA	13,660,150	(6,499,017)	7,150,769
MVP Health Insurance	(79,297,376)	NA	NA	NA	NA	(79,297,376)
Oxford Health Insurance (UnitedHealthcare)	182,149,931	NA	NA	NA	NA	182,149,931
UnitedHealthcare Insurance Co.	55,625,502	(6,737,808)	NA	19,089,908	29,399,070	97,376,672
Article 42 Total	209,724,400	16,941,134	(17,890,476)	40,425,275	42,370,759	291,571,092

Prepaid Health Services Plans	Medicaid	Family Health Plus	Child Health Plus	TOTAL (all programs)**
Affinity Health Plan	13,149,474	(2,207,210)	13,119	12,969,610
Amerigroup	(732,424)	(379,402)	(2,005,846)	(6,405,559)
HealthFirst	(4,344,422)	(580,028)	(768,244)	(5,526,587)
HealthPlus	5,822,867	(11,354,343)	(4,818,324)	(12,040,057)
Hudson Health Plan	(2,275,793)	(628,635)	700,365	(2,439,662)
MetroPlus	55,063,394	5,317,603	(209,599)	68,006,825
Neighborhood Health Providers	(7,680,153)	(2,928,276)	(3,547,712)	(14,156,141)
NYS Catholic Health Plan (Fidelis Care)	19,667,911	(8,615,403)	3,609,769	8,609,754
SCHC Total Care	(988,186)	385,525	(64,613)	(667,274)
Univera Community Health	11,677,062	2,944,055	(449,662)	14,171,455
WellCare	6,506,609	(1,884,245)	(633,829)	18,770,453
PHSP Total	95,866,339	(19,930,359)	(8,174,576)	81,292,817

HMO Line of Business for Article 43 Nonprofit Insurers***	Large Group	Small Group	Individual	Healthy New York	Medicare	Medicaid	Family/Child Health Plus	TOTAL
Excellus BCBS	28,917,344	1,691,302	2,533,479	(2,788,635)	10,281,521	5,476,547	2,620,342	48,731,900
HIP (EmblemHealth)	91,738,646	2,032,509	197,153	(1,791,006)	91,847,939	19,848,237	3,426,594	207,300,072
Community Blue (HealthNow BCBS)	7,397,925	(2,047,612)	294,660	(1,757,015)	4,332,155	2,508,369	986,665	11,715,147

** Total net income for PHSPs includes gains and losses from other programs not shown here, including Employer Buy-In, Medicaid Advantage, and Medicaid Advantage Plus.

*** These are HMO line of business results, part of the total results shown above for the corresponding Article 43 parent companies.

Notes: Based on underwriting revenues and expenses, not including investment income or income taxes and not including results on dental or vision plans. Because of revenue, net income, or losses that are not reflected in the categories summarized in this table, data in rows for individual health plans may not equal the totals reported for those plans.

Source: Authors' analysis of annual statements for health plans. For HMOs and Article 43 nonprofit insurers, New York State supplement reports. For Accident and Health companies, NAIC page 7. For PHSPs, annual Medicaid Managed Care Operating Reports, Department of Health.

Table 5. **Medicare Managed Care Plan Financial Results, 2010**

Article 44 HMOs	Member Months	Per Member Per Month					Medical Loss Ratio	Operating Margin
		Premium	Medical Expenses	Spread	Admin Expenses	Net Income		
Aetna Health	184,991	$1,082.01	$927. 23	$154.78	$78.21	$76.57	85.7%	7.1%
Arcadian Health Plan	14,353	765.95	659.36	106.60	165.66	(59.06)	86.1%	-7.7%
CDPHP	254,089	890.61	803.29	87.32	75.21	12.12	90.2%	1.4%
Catholic Special Needs Plan	9,822	2,875.69	2,079.66	796.03	640.55	155.48	72.3%	5.4%
Community Blue HMO (HealthNow BCBS)	458,648	888.49	822.92	65.57	56.12	9.45	92.6%	1.1%
ElderPlan	186,805	1,122.71	1,015.41	107.30	193.64	(28.67)	90.4%	-2.6%
Empire BCBS HMO	760,429	1,116.50	889.34	227.16	79.52	133.92	79.7%	12.0%
Essence Healthcare	18,625	755.84	652.22	103.62	207.27	(103.66)	86.3%	-13.7%
Excellus BCBS HMO	653,294	851.04	757.26	93.78	73.29	15.74	89.0%	1.8%
HIP (EmblemHealth)	1,513,293	1,275.89	1,099.09	176.80	115.93	60.69	86.1%	4.8%
Independent Health Association	643,292	955.66	825.54	130.13	68.17	61.96	86.4%	6.5%
Managed Health (HealthFirst)	1,091,933	1,183.50	1,010.52	172.98	161.09	11.91	85.4%	1.0%
MVP Health Plan	1,184,548	928.23	821.63	106.60	62.62	43.98	88.5%	4.7%
Oxford Health Plan (UnitedHealthcare)	848,406	1,014.24	798.88	215.36	105.07	106.57	78.8%	10.5%
Senior Whole Health	18	2,106.61	1,434.61	672.00	557.61	131.72	68.1%	6.3%
Touchstone Health HMO	186,429	1,117.76	957.29	160.47	167.79	(7.31)	85.6%	-0.7%
UnitedHealthcare HMO	123,614	1,726.18	1,141.44	584.74	198.72	390.08	66.1%	22.6%
Total*	8,132,589	1,072.44	912.89	159.55	102.15	56.70	85.1%	5.3%

* In Total row, medical loss ratio and operating margin are expressed as an average percentage, not as a sum, and spread is the difference between premiums collected and medical expenses.

Source: Authors' analysis of HMO annual statements, New York supplement. Includes Medicare Advantage plans with and without Part D prescription drug coverage.

Table 6. **Enrollment in Stand-Alone Medicare Prescription Drug Plans, January 2011 and January 2010**

Part D Plan	2011	2010
UnitedHealthcare Insurance Co.	226,900	205,260
CVS Caremark (Silverscript Insurance/Accendo Insurance)	169,011	156,475
American Progressive Insurance Co. of NY (Universal American)	114,234	118,370
CIGNA	100,148	89,356
EmblemHealth (GHI/HIP)	82,999	127,360
HealthSpring Insurance Co./Bravo Health Insurance Co.	65,486	55,470
Medco Containment Insurance Co.	64,801	55,533
Humana Insurance Co. of New York	44,931	44,216
WellCare Prescription Insurance	30,872	20,111
Envision Insurance	22,336	8,682
Coventry	17,451	17,179
Excellus BCBS	16,360	16,817
UniCare Life and Health (WellPoint/Empire BCBS)	10,646	16,764
Express Scripts Insurance Co.	9,898	6,008
First United American	6,594	7,042
Aetna Life Insurance Co.	5,012	6,667
Sterling Life Insurance Co.	813	950
IBT Voluntary Employee Benefits Trust	611	594
Fox Insurance*	NA	8,285
Health Net Insurance of NY (UnitedHealthcare)**	73	11,374
Other (<500)	1,459	1,416
Total	990,635	973,929

* Terminated from Medicare Part D in 2010.

** UnitedHealthcare completed acquisition of Health Net in November 2009 and began operating Health Net Insurance of NY Medicare Part D plans on January 1, 2011.

Note: Enrollment in multiple plans with a common parent company is combined. For privacy reasons, CMS does not report data by health plans for counties in which a health plan has fewer than 10 enrollees.

Source: Authors' analysis of CMS State/County/Contract Medicare Advantage Monthly Enrollment Report, January 2010 and 2011. Available online at http://www.cms.gov/MCRAdvPartDEnrolData/MPDPESCC/list.asp#TopOfPage

Table 7. **New York Medicare Supplement Enrollment by Health Plan, 2010**

UnitedHealthcare Insurance Co.	224,492
Empire BCBS	52,290
Excellus BCBS	19,137
American Progressive Insurance Co. of NY (Universal American)	3,928
First United American	8,713
Mutual of Omaha	7,511
Transamerica Financial Life	5,402
Bankers Conseco Life & Casualty Co.	1,163
EmblemHealth (GHI/HIP)	2,668
HealthNow BCBS	4,283
Other	3,192
Total	332,779

Note: Enrollment for commonly owned subsidiaries grouped together.

Source: New York State Insurance Department, personal communication, June 2012. Enrollment as of December 31, 2010.

Table 8. **Medicaid Managed Care Plan Financial Results, 2010**

Prepaid Health Services Plans	Member Months	Per Member Per Month					Medical Loss Ratio	Operating Margin
		Premium	Medical Expenses	Spread	Admin Expenses	Net Income		
Affinity Health Plan	2,447,833	$262.11	$233.52	$28.59	$23.84	$2.08	89.1%	0.8%
Amerigroup	988,025	210.64	165.14	45.50	44.36	3.22	78.4%	1.5%
HealthFirst	4,561,099	261.64	240.78	20.87	23.85	(0.05)	92.0%	0.0%
HealthPlus	2,895,921	246.48	220.81	25.67	25.40	5.13	89.6%	2.1%
Hudson Health Plan	826,849	311.29	293.33	17.97	28.68	(7.51)	94.2%	-2.4%
MetroPlus	3,963,116	240.37	208.68	31.68	20.27	9.57	86.8%	4.0%
Neighborhood Health Providers	2,117,664	258.61	239.97	18.65	25.25	0.54	92.8%	0.2%
NYS Catholic Health Plan (Fidelis Care)	5,293,593	243.11	218.31	24.80	21.91	9.90	89.8%	4.1%
SCHC Total Care	395,307	246.57	225.28	21.28	23.78	(5.12)	91.4%	-2.1%
Univera Community Health	385,134	252.95	193.36	59.59	31.49	13.19	76.4%	5.2%
WellCare	803,625	217.08	182.48	34.60	32.84	7.65	84.1%	3.5%
PHSP Total*	24,678,166	250.05	223.52	26.53	24.55	4.76	89.4%	1.9%

Article 44 HMOs	Member Months	Per Member Per Month					Medical Loss Ratio	Operating Margin
		Premium	Medical Expenses	Spread	Admin Expenses	Net Income		
CDPHP	664,589	$254.82	$219.93	$34.89	$31.38	$6.12	86.3%	2.4%
Excellus BCBS HMO	1,262,692	265.71	242.16	23.55	22.69	3.62	91.1%	1.4%
HIP (EmblemHealth)	2,651,275	276.65	234.29	42.36	38.52	3.74	84.7%	1.4%
Community Blue HMO (HealthNow BCBS)	431,426	259.98	238.48	21.50	22.52	4.62	91.7%	1.8%
Independent Health Association	408,203	272.23	250.15	22.08	23.17	8.21	91.9%	3.0%
MVP Health Plan	384,639	282.86	240.70	42.15	35.71	12.47	85.1%	4.4%
UnitedHealthcare HMO	2,437,608	255.54	207.17	48.37	32.60	12.20	81.1%	4.8%
HMO Total*	8,240,432	266.17	227.62	38.55	32.04	7.09	85.5%	2.7%

* In Total rows, medical loss ratio and operating margin are expressed as an average percentage, not as a sum.

Source: Authors' analysis of 2010 Medicaid Managed Care Operating Reports, New York Department of Health.

Table 9. **Commercial Health Plan Premiums and Medical Expenses Per Member Per Month, 2009-2010**

Article 44 HMOs	2009 Premium Revenue	2009 Medical Expense	2009 Spread	2010 Premium Revenue	2010 Medical Expense	2010 Spread	Change from 2009 to 2010 Premium Revenue	Change from 2009 to 2010 Medical Expense
Aetna Health	$473.27	$401.43	$71.83	$505.84	$425.53	$80.30	6.9%	6.0%
Atlantis Health Plan	310.57	288.27	22.30	342.80	262.42	80.38	10.4%	-9.0%
CDPHP	344.68	301.84	42.83	376.13	315.02	61.11	9.1%	4.4%
CIGNA HealthCare	375.34	348.47	26.88	NA	NA	NA	NA	NA
Empire BCBS HMO	451.15	388.93	62.22	521.95	419.64	102.31	15.7%	7.9%
GHI HMO (EmblemHealth)	395.18	307.90	87.28	471.96	374.93	97.03	19.4%	21.8%
Health Net of NY (UnitedHealthcare)	387.44	332.76	54.69	402.34	368.08	34.26	3.8%	10.6%
Independent Health Association	378.97	359.90	19.07	429.40	362.64	66.76	13.3%	0.8%
MVP Health Plan	348.73	297.44	51.28	404.62	339.62	65.00	16.0%	14.2%
Oxford Health Plan (UnitedHealthcare)	472.53	391.83	80.71	492.42	390.31	102.11	4.2%	-0.4%
Subtotal	404.63	347.85	56.78	448.28	369.52	78.76	10.8%	6.2%

Article 43 Nonprofit Insurers	2009 Premium Revenue	2009 Medical Expense	2009 Spread	2010 Premium Revenue	2010 Medical Expense	2010 Spread	Change from 2009 to 2010 Premium Revenue	Change from 2009 to 2010 Medical Expense
CDPHP Universal Benefits	306.15	276.11	30.04	329.58	281.00	48.57	7.7%	1.8%
Excellus BCBS	284.87	255.10	29.77	297.76	262.40	35.36	4.5%	2.9%
Group Health Inc. (EmblemHealth)	186.86	169.72	17.14	192.28	174.71	17.56	2.9%	2.9%
HIP (EmblemHealth)	356.21	311.04	45.16	393.31	332.36	60.95	10.4%	6.9%
HealthNow BCBS	310.51	278.36	32.15	331.67	287.25	44.42	6.8%	3.2%
Independent Health Benefits	281.88	252.31	29.57	307.73	272.72	35.01	9.2%	8.1%
Preferred Assurance (MVP Health Care)	168.04	159.64	8.40	251.63	239.07	12.56	49.7%	49.8%
Subtotal	264.58	236.73	27.86	277.25	243.64	33.61	4.8%	2.9%

Note: MVP Health Plan data for 2009 is consolidated with the former Rochester Area HMO.

Source: Authors' analysis of health plan annual statements; New York supplements for HMOs and "Analysis of Operations by Lines of Business" for nonprofit health insurers.

Table 10. **Administrative Expenses for New York Health Plans, 2009-2010**

Article 44 HMOs	Administrative Expenses	As % of Revenues	2010 Expenses PMPM	2009 Expenses PMPM
Aetna Health	$54,913,963	7.8%	$45.37	$47.44
Arcadian Health Plan	2,377,693	21.6%	165.66	546.03
Atlantis Health Plan	26,966,244	23.9%	78.53	81.39
CDPHP	116,686,067	11.5%	42.38	39.03
Catholic Special Needs Plan	6,291,449	22.3%	640.55	621.81
CIGNA HealthCare*	(81,780)	-1432.5%	NA	242.83
ElderPlan	38,170,932	17.6%	202.98	204.69
Empire BCBS HMO	156,580,388	8.0%	43.25	43.27
Essence Health Care	3,860,459	27.4%	207.27	NA
GHI HMO (EmblemHealth)	12,467,407	27.7%	124.26	49.67
Health Net of NY (UnitedHealthcare)	48,038,153	18.5%	73.54	67.72
Independent Health Association	97,036,368	8.9%	50.16	51.26
Managed Health (HealthFirst)	176,280,982	13.6%	160.52	164.05
MVP Health Plan	186,587,693	9.0%	48.91	41.36
Oxford Health Plan (UnitedHealthcare)	230,594,584	11.3%	67.22	52.54
Quality Health Plans**	525,132	347.6%	2,652.18	NA
Senior Whole Health	4,810,167	22.8%	562.92	566.39
Touchstone Health HMO	33,270,387	15.0%	167.81	250.66
UnitedHealthcare HMO	128,674,723	13.2%	40.33	36.95
Article 44 Subtotal	1,324,051,011	10.9%	58.62	52.89

Article 43 Nonprofit Insurers	Administrative Expenses	As % of Revenues	2010 Expenses PMPM	2009 Expenses PMPM
CDPHP Universal Benefits	42,018,797	12.6%	44.76	42.91
Excellus BCBS	578,530,944	11.2%	31.48	30.69
Group Health Inc. (EmblemHealth)	421,098,992	11.7%	20.28	18.38
HIP (EmblemHealth)	525,422,774	10.7%	53.46	54.35
HealthNow BCBS	244,179,323	10.2%	40.68	38.09
Independent Health Benefits	53,352,135	11.2%	37.19	32.87
Preferred Assurance (MVP Health Care)	8,127,802	12.6%	31.64	25.80
Article 43 Subtotal	1,872,730,767	11.1%	32.51	31.75

Article 42 Accident and Health Insurers	Administrative Expenses	As % of Revenues	2010 Expenses PMPM	2009 Expenses PMPM
Aetna Health Insurance Co. of NY	898,980	10.2%	3.81	3.01
Empire BCBS	431,168,620	8.7%	18.83	16.18
Freelancers Insurance Co.	15,337,115	18.5%	58.51	55.73
Health Net Insurance of NY (UnitedHealthcare)	111,311,597	18.7%	78.07	41.29
HIP Insurance Co. (EmblemHealth)	22,402,496	11.2%	21.13	14.59
Humana Insurance Co. of NY	15,527,349	11.3%	25.40	20.05
MVP Health Insurance	122,972,653	17.7%	51.77	47.86
Oxford Health Insurance (UnitedHealthcare)	299,841,808	12.4%	24.83	19.63
UnitedHealthcare Insurance Co.	169,297,999	10.5%	7.94	7.90
WellCare Health Insurance of NY***	(1,098,218)	-967.1%	NA	117.87
Article 42 Subtotal	1,187,660,399	11.1%	19.07	15.85
Total	4,384,442,177	11.0%	30.78	27.90

* Refunds of state regulatory licensing fees previously paid by CIGNA, which withdrew its HMO license in 2010 and had no membership, account for the unusual ratio of administrative expenses to revenues and the inability to calculate a PMPM figure.

** Quality Health Plans commenced business in 2010 and had fewer than 20 enrollees.

*** WellCare Health Insurance had no enrollment in 2010.

Source: Authors' analysis of NAIC annual statements for health plans.

Table 11. **Capitation Payments by New York Health Plans, 2010**

Article 44 HMOs	Capitation Payments	Total Medical Payments	% Paid Through Capitation 2010	2009	2008
Aetna Health	$22,270,540	$619,446,562	3.6%	4.1%	5.8%
Arcadian Health Plan	254,508	8,580,918	3.0%	NA	NA
Atlantis Health Plan	0	88,248,716	0.0%	0.0%	0.0%
CDPHP	12,351,742	871,853,863	1.4%	4.1%	4.1%
Catholic Special Needs Plan	579,139	17,379,258	3.3%	0.0%	0.0%
CIGNA HealthCare	0	26,970	0.0%	3.3%	6.8%
ConnectiCare of NY (EmblemHealth)	374	223,185	0.2%	0.1%	0.2%
ElderPlan	10,681,796	202,792,612	5.3%	5.2%	5.2%
Empire BCBS HMO	79,910,044	1,624,166,647	4.9%	5.2%	6.3%
Essence Healthcare	1,233,034	11,776,453	10.5%	NA	NA
GHI HMO (EmblemHealth)	150,597	47,534,130	0.3%	2.2%	2.8%
Health Net of NY (UnitedHealthcare)	9,213,095	231,715,365	4.0%	9.8%	12.6%
Independent Health Association	717,164,988	927,613,206	77.3%	82.6%	98.1%
Managed Health (HealthFirst)	11,139,487	1,158,186,162	1.0%	1.0%	0.9%
MVP Health Plan	682,749,713	1,844,014,514	37.0%	38.8%	1.9%
Oxford Health Plan (UnitedHealthcare)	94,015,271	1,677,950,885	5.6%	5.1%	4.4%
Quality Health Plans	3,414	48,348	7.1%	NA	NA
Senior Whole Health	0	20,479,330	0.0%	0.0%	0.0%
Touchstone Health HMO	43,703,968	133,791,875	32.7%	7.1%	8.9%
UnitedHealthcare HMO	36,294,588	750,264,003	4.8%	6.2%	5.7%
Article 44 Total	1,721,716,298	10,236,093,002	16.8%	17.9%	18.8%

Article 43 Nonprofit Insurers	Capitation Payments	Total Medical Payments	% Paid Through Capitation 2010	2009	2008
CDPHP Universal Benefits	2,523,798	279,951,292	0.9%	3.6%	3.5%
Excellus BCBS	430,411,926	4,539,048,786	9.5%	8.8%	8.0%
Group Health Inc. (EmblemHealth)	1,274,266	3,175,473,528	0.0%	0.1%	0.1%
HIP (EmblemHealth)	1,302,339,063	4,168,651,031	31.2%	30.1%	29.6%
HealthNow BCBS	33,901,759	2,136,087,316	1.6%	1.9%	1.8%
Independent Health Benefits	0	423,867,757	0.0%	0.2%	0.3%
Preferred Assurance (MVP Health Care)	0	63,960,652	0.0%	0.0%	0.0%
Article 43 Total	1,770,450,812	14,787,040,362	12.0%	11.9%	11.7%

Source: Authors' analysis of health plan annual statements, Table 7.

Table 12. **Health Plan Surplus and Risk-Based Capital Ratios, 2010 and 2009**

Article 44 HMOs	2009 Surplus	2010 Surplus	2010 Surplus Per Member	Risk-Based Capital Ratio 2010	Risk-Based Capital Ratio 2009
Aetna Health	$183,104,408	$175,997,106	$1,797	850%	772%
Arcadian Health Plan	810,763	1,387,595	953	226%	267%
Atlantis Health Plan	(18,175,949)	(18,325,516)	(690)	-400%	-401%
CDPHP	230,310,025	270,342,156	1,190	701%	596%
Catholic Special Needs Plan	2,707,965	4,294,675	4,689	347%	265%
CIGNA HealthCare	22,431,355	24,183,637	NA	6719%	6200%
ConnectiCare NY (EmblemHealth)	6,505,928	6,693,945	230,826	6657%	6499%
ElderPlan	45,287,163	37,938,911	2,459	462%	531%
Empire BCBS HMO	482,308,422	559,427,176	1,963	917%	668%
Essence Healthcare	2,409,682	937,154	551	105%	NA
GHI HMO (EmblemHealth)	28,761,546	26,470,720	3,520	1404%	463%
Health Net of NY (UnitedHealthcare)	61,994,120	40,585,749	915	415%	482%
Independent Health Association	374,277,176	451,284,652	2,779	1397%	1264%
Managed Health (HealthFirst)	132,721,702	160,089,090	1,707	371%	324%
MVP Health Plan	327,209,486	329,794,564	1,065	616%	469%
Oxford Health Plan (UnitedHealthcare)*	366,602,578	494,687,594	1,594	333%	264%
Senior Whole Health	4,836,473	2,989,505	3,818	194%	344%
Touchstone Health HMO	(24,150,623)	(2,105,351)	(125)	-28%	-258%
UnitedHealthcare HMO	167,155,731	248,161,275	899	846%	616%
Article 44 Total	2,397,107,951	2,814,834,637	1,499	607%	562%

Article 43 Nonprofit Insurers	2009 Surplus	2010 Surplus	2010 Surplus Per Member	Risk-Based Capital Ratio 2010	Risk-Based Capital Ratio 2009
CDPHP Universal Benefits	28,330,910	30,095,117	368	291%	364%
Excellus BCBS	965,052,547	1,089,671,571	709	576%	542%
Group Health Inc. (EmblemHealth)	146,385,802	213,118,755	123	168%	128%
HIP (EmblemHealth)	923,058,799	1,184,459,616	1,476	741%	569%
HealthNow BCBS	546,244,022	567,544,641	1,128	684%	649%
Independent Health Benefits	92,866,810	99,673,156	862	507%	482%
Preferred Assurance (MVP Health Care)	7,227,298	8,849,610	424	257%	173%
Article 43 Total	2,709,166,188	3,193,412,466	666	539%	476%

Article 42 Accident and Health Insurers	2009 Surplus	2010 Surplus	2010 Surplus Per Member	Risk-Based Capital Ratio 2010	Risk-Based Capital Ratio 2009
Aetna Health Insurance Co. of NY	8,370,434	8,918,586	496	1187%	1114%
Empire BCBS	1,363,197,514	1,531,146,294	1,011	881%	517%
Freelancers Insurance Co.	9,471,813	10,775,398	490	353%	287%
Health Net Insurance of NY (UnitedHealthcare)	124,881,982	152,664,552	2,374	701%	801%
HIP Insurance Co. (EmblemHealth)	27,480,584	17,277,644	204	217%	358%
Humana Insurance Co. of NY	75,418,825	73,627,494	1,477	3494%	2244%
MVP Health Insurance	56,138,004	75,986,429	379	300%	340%
Oxford Health Insurance (UnitedHealthcare)	315,084,493	432,577,929	418	562%	427%
UnitedHealthcare Insurance Co.	436,954,209	489,893,488	273	3690%	2565%
WellCare Health Insurance of NY	10,310,703	11,968,125	NA	1590%	470%
Article 42 Total	2,427,308,561	2,804,835,939	587	861%	601%

* Oxford Health Insurance is a wholly owned subsidiary of Oxford Health Plans of New York HMO. To avoid double-counting, we eliminated the value of the parent company's investment in the subsidiary ($432.6 million in 2010, according to Schedule D) from the calculation of the HMO's surplus and risk-based capital ratio.

Note: A risk-based capital ratio of at least 200 percent is required; below that the state regulator will take inspection and enforcement actions.

Source: Authors' analysis of health plan annual statements. Data from Five-Year Historical Data pages in NAIC statements. Surplus per member calculated excluding enrollment in dental- and vision-only plans.

Table 13. **Medical Loss Ratios by Line of Business, 2009-2010**

	Large Group		Small Group		Individual		Healthy New York	
Article 44 HMOs	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**
Aetna Health	84.3%	82.6%	76.0%	87.6%	91.8%	90.4%	102.8%	84.4%
Atlantis Health Plan	117.7%	69.0%	55.2%	78.7%	72.4%	62.4%	74.6%	79.0%
CDPHP	87.3%	84.4%	88.2%	81.6%	99.6%	55.1%	79.6%	81.2%
CIGNA HealthCare	NA	NA	NA	NA	NA	NA	NA	NA
Community Blue HMO (HealthNow BCBS)	89.0%	84.5%	94.4%	86.9%	35.6%	79.3%	79.6%	97.8%
Empire BCBS HMO	80.3%	78.8%	93.2%	86.7%	68.4%	65.5%	79.4%	78.3%
Excellus BCBS HMO	85.5%	77.4%	85.6%	79.8%	82.7%	68.7%	90.6%	93.0%
GHI HMO (EmblemHealth)	79.0%	78.4%	78.9%	96.2%	1.1%	68.0%	82.5%	78.3%
Health Net of NY (UnitedHealthcare)	94.7%	94.6%	76.5%	88.4%	85.5%	68.1%	71.5%	92.4%
HIP (EmblemHealth)	87.2%	84.9%	95.2%	87.5%	80.8%	85.2%	77.7%	96.4%
Independent Health Association	85.0%	83.9%	84.9%	88.8%	85.6%	99.6%	84.6%	80.7%
Managed Health (HealthFirst)	NA	NA	NA	85.3%	NA	85.3%	85.2%	85.2%
MVP Health Plan	82.5%	82.5%	96.7%	93.6%	105.3%	166.9%	80.2%	83.7%
Oxford Health Plan (UnitedHealthcare)	82.6%	79.6%	83.8%	77.4%	81.3%	89.5%	73.0%	101.4%
Article 44 Total	85.3%	83.3%	87.9%	82.9%	79.1%	80.3%	80.8%	86.4%

	Large Group		Small Group		Direct Pay/ Group Conversion		Experience-Rated Groups	
Article 43 Nonprofit Insurers	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**
CDPHP Universal Benefits	NA	NA	89.7%	81.2%	98.9%	104.5%	89.7%	86.4%
Excellus BCBS	81.6%	87.0%	88.3%	87.5%	84.9%	88.0%	89.7%	88.8%
Group Health Inc. (EmblemHealth)	NA	NA	90.4%	NA	92.4%	84.0%	89.4%	89.1%
HIP (EmblemHealth)	87.5%	85.0%	NA	NA	79.3%	90.0%	NA	NA
HealthNow BCBS	86.9%	88.7%	88.6%	92.2%	88.0%	91.9%	89.2%	85.1%
Independent Health Benefits	NA	NA	88.1%	90.5%	90.8%	95.7%	87.6%	85.4%
Preferred Assurance (MVP Health Care)	76.1%	1057.7%	107.5%	121.8%	NA	NA	96.5%	90.5%
Article 43 Total	87.4%	85.3%	89.7%	90.6%	87.6%	88.4%	89.5%	88.1%

Source: Authors' analysis of health plan annual statements: New York supplements for Article 43 and Article 44 companies; NAIC state enrollment pages for Article 42 companies.

Table 13. **Medical Loss Ratios by Line of Business, 2009-2010** (cont.)

	Individual		Group		Federal Employees	
Article 42 Accident and Health Companies	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**
Aetna Health Insurance Co. of NY	NA	NA	96.4%	80.3%	NA	NA
Empire BCBS	81.6%	52.7%	90.4%	87.7%	93.8%	100.0%
Freelancers Insurance Co.	NA	NA	87.9%	81.3%	NA	NA
Health Net Insurance of NY (UnitedHealthcare)	NA	NA	89.7%	94.1%	NA	NA
HIP Insurance Co. (EmblemHealth)	160.0%	197.4%	93.6%	97.4%	NA	NA
MVP Health Insurance	NA	NA	98.4%	93.9%	NA	NA
Oxford Health Insurance (UnitedHealthcare)	79.1%	68.7%	82.5%	80.6%	NA	NA
UnitedHealthcare Insurance Co.	255.7%	265.7%	90.4%	89.0%	NA	NA
Article 42 Total	89.7%	62.8%	88.7%	86.8%	93.8%	100.0%

Source: Authors' analysis of health plan annual statements: New York supplements for Article 43 and Article 44 companies; NAIC state enrollment pages for Article 42 companies.

Table 14. **New York Health Plan Comprehensive Group Enrollment by Region, 2010**

Article 44 HMOs	New York City	Metropolitan Suburban	Northern	Central	Western	Total
Aetna Health	38,336	33,586	1,625	286	NA	73,833
Atlantis Health Plan	20,542	975	NA	NA	NA	21,517
CDPHP	117	1,347	112,199	1,101	1	114,765
Community Blue HMO (HealthNow BCBS)	9	8	8,295	276	34,024	42,612
Empire BCBS HMO	51,490	42,119	5,807	39	5	99,460
Excellus BCBS HMO	97	142	470	50,562	1,656	52,927
GHI HMO (EmblemHealth)	2,354	1,697	2,152	191	NA	6,394
Health Net of NY (UnitedHealthcare)	37,575	3,549	1,625	NA	NA	42,749
HIP (EmblemHealth)	332,395	58,770	15,264	1	NA	406,430
Independent Health Association	NA	NA	NA	NA	63,930	63,930
MVP Health Plan	33	6,957	76,721	55,519	3,331	142,561
Oxford Health Plan (UnitedHealthcare)	120,134	66,121	663	2	7	186,927
Article 44 Subtotal	603,082	215,271	224,821	107,977	102,954	1,254,105

Article 43 Nonprofit Insurers	New York City	Metropolitan Suburban	Northern	Central	Western	Total
CDPHP Universal Benefits	18	304	77,322	3,901	NA	81,545
Excellus BCBS	140	576	117,731	947,869	47,608	1,113,924
Group Health Inc. (Emblem Health)	756,003	448,831	154,598	130,598	67,949	1,557,979
HealthNow BCBS	1,128	3,382	96,151	7,618	256,565	364,844
Independent Health Benefits	NA	NA	NA	NA	113,550	113,550
Preferred Assurance (MVP Health Care)	NA	NA	4	15,303	382	15,689
Article 43 Subtotal	757,289	453,093	445,806	1,105,289	486,054	3,247,531

Article 42 Accident/Health Insurers	New York City	Metropolitan Suburban	Northern	Central	Western	Total
Empire BCBS*	392,375	514,205	225,127	109,045	33,894	1,274,646
Freelancers Insurance Co.	22,003	NA	NA	NA	NA	22,003
Health Net Insurance of NY (UnitedHealthcare)	33,151	23,536	134	NA	NA	56,821
MVP Health Insurance	1,604	16,411	66,340	59,508	9,701	153,564
Oxford Health Insurance (UnitedHealthcare)	512,883	246,537	11,120	23	7	770,570
UnitedHealthcare Insurance Co.	179,912	614,424	230,115	193,682	55,154	1,273,287
Article 42 Subtotal	1,141,928	1,415,113	532,836	362,258	98,756	3,550,891
Total	2,502,299	2,083,477	1,203,463	1,575,524	687,764	8,052,527

* Enrollment based on county of employer except that Empire HealthChoice Assurance was restated to reflect distribution of enrollees in New York State Health Insurance Plan (state and other participating public agencies) by county of residence, projected from data provided by the Department of Civil Service.

Note: Limited to enrollment in HMO large and small commercial groups; Article 43 provider service organizations, preferred provider organizations, point of service plans, and indemnity only plans; and Article 42 life, accident, and health large and small group comprehensive.

Source: Authors' analysis of health insurer annual statements, New York State supplement reports.

Table 15. **Medicaid Managed Care Enrollment by Region, 2010**

Prepaid Health Services Plans	New York City	Metropolitan Suburban	Northern	Central	Western	Total
Affinity Health Plan	158,560	55,055	NA	NA	NA	213,615
Amerigroup	81,278	191	NA	NA	NA	81,469
HealthFirst	364,321	27,842	NA	NA	NA	392,163
HealthPlus	240,451	7,000	NA	NA	NA	247,451
Hudson Health Plan	NA	54,764	16,323	NA	NA	71,087
MetroPlus	339,364	NA	NA	NA	NA	339,364
Neighborhood Health Providers	157,353	15,754	NA	NA	NA	173,107
NYS Catholic Health Plan (Fidelis Care)	227,641	85,546	47,446	67,975	49,800	478,408
SCHC Total Care	NA	NA	NA	34,427	NA	34,427
Univera Community Health	NA	NA	NA	NA	33,088	33,088
WellCare	50,071	4,314	8,416	NA	NA	62,801
PHSP Subtotal	1,619,039	250,466	72,185	102,402	82,888	2,126,980

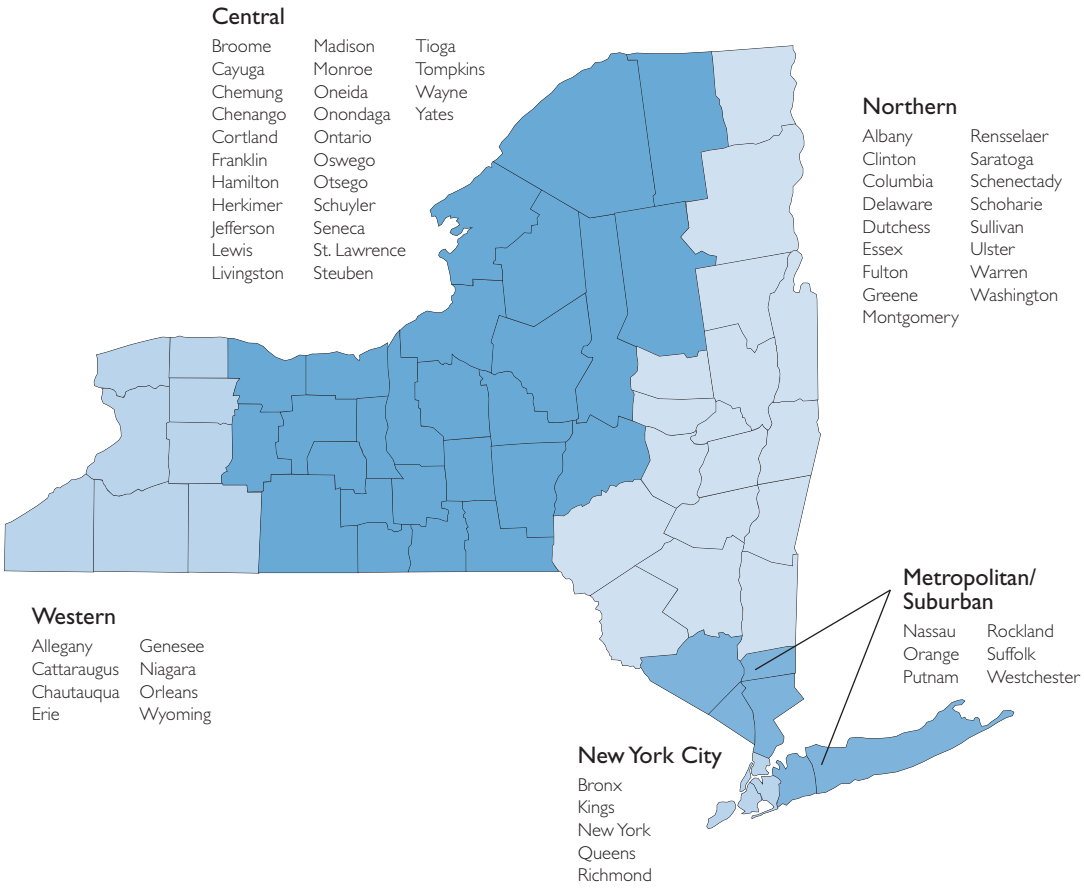
Article 44 HMOs	New York City	Metropolitan Suburban	Northern	Central	Western	Total
CDPHP	NA	NA	56,417	827	NA	57,244
Community Blue HMO (HealthNow BCBS)	NA	NA	NA	NA	36,333	36,333
Excellus BCBS HMO	NA	NA	1	107,692	1,858	109,551
HIP (EmblemHealth)	176,947	38,281	NA	NA	NA	215,228
Independent Health Association	NA	NA	NA	NA	35,677	35,677
MVP Health Plan	NA	NA	11,034	18,441	1,925	31,400
UnitedHealthcare HMO	166,515	32,549	NA	12,098	NA	211,162
HMO Subtotal	343,462	70, 830	67,452	139,058	75,793	696,595
Total	1,962,501	321,296	139,637	241,460	158,681	2,823,575

Source: Authors' analysis of 2010 Medicaid Managed Care Operating Reports, New York Department of Health.

Counties within Regions Used for This Analysis (Tables 14-15)

New York City:	Bronx, Kings, New York, Queens, Richmond.
Metropolitan/Suburban:	Nassau, Orange, Putnam, Rockland, Suffolk, Westchester.
Northern:	Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington.
Central:	Broome, Cayuga, Chemung, Chenango, Cortland, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Otsego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Yates.
Western:	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming.

Tables 14 and 15. **New York State Map: Counties within Regions**



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