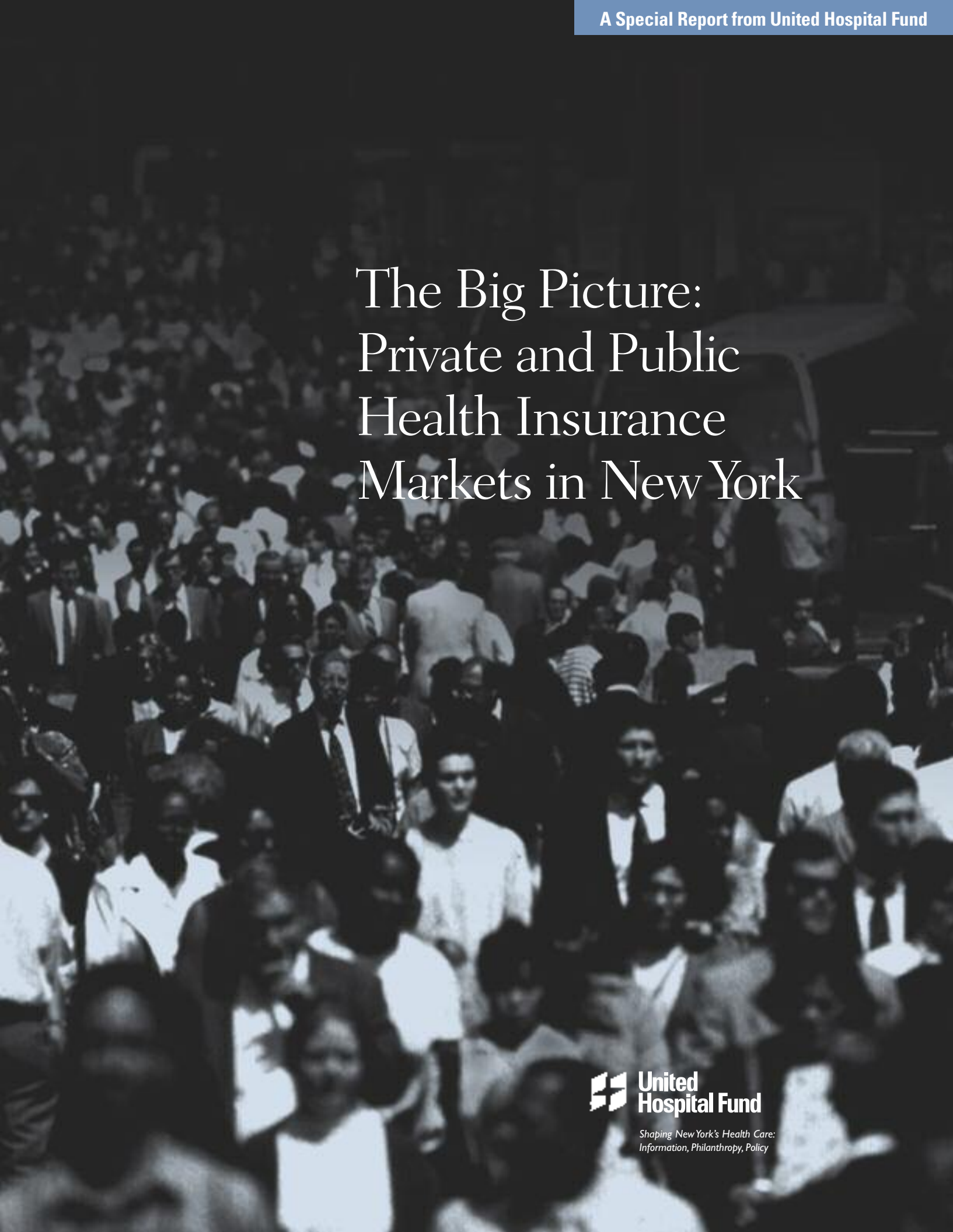
A Special Report from United Hospital Fund

The Big Picture: Private and Public Health Insurance Markets in New York



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 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, clinics, 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.

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The Big Picture: Private and Public Health Insurance Markets in New York

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

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Foreword

In 1984, the New York State Council on Health Care Financing's Subcommittee on Health Insurance, which I chaired, published *Health Insurance — Public Policy in New York*, a phonebook-sized analysis of health markets, programs, and issues, and our best thoughts on how to meet the challenges ahead. Twenty-five years later, I am pleased to release an ambitious update, *The Big Picture: Private and Public Health Insurance Markets in New York*.

Less prescriptive than that earlier work, *The Big Picture* presents and contrasts detailed portraits of four segments of our health insurance system here in New York: the fully insured commercial market, the self-funded market, state public managed care programs, and Medicare coverage provided by health plans. Since analysts tend to view each of these segments separately, I found this combination refreshing and thought-provoking.

At the core of this report are in-depth statistical tables on health plan enrollment and financial results for 2006, developed by Allan Baumgarten through an exhaustive analysis of annual statements filed by plans with state regulators. United Hospital Fund Health Insurance Project Co-Director Peter Newell wrote this report, fleshing out the statistical side with an in-depth review of how these markets really work — the buyers, sellers, benefits, and premiums paid. Along the way, we highlight major market features such as the Empire Plan — New York State's health insurance program for 1.25 million public employees, retirees, and dependents. We also review the key laws and regulations that underpin our system, describe how they are being implemented, and provide some historical perspective.

Pound for pound, this is certainly one of the bigger reports published by the Fund lately — not for the faint of heart — but an interesting and timely one that merits its volume. We believe you will find it a useful reference and roadmap for some of the major decisions state policymakers and regulators face. By providing a rich description of how our health insurance markets work and how we got there, *The Big Picture* informs the discussion of "what's next?" at this critical juncture for health care reform here in New York and in the nation.

James R. Tallon, Jr.
President
United Hospital Fund

Acknowledgments

The New York State Health Foundation supported this work; we're grateful to President and CEO James Knickman and Senior Vice President David Sandman for that support.

A long list of professionals — too numerous to name here — at the New York State Insurance Department, New York State Department of Civil Service, New York State Department of Health, Governor's Office of Employee Relations, and New York City Office of Labor Relations gave generously of their time, expertise, and institutional memories. Special thanks go to Dawn Livingston of the Insurance Department, who was unfailingly pleasant and helpful during the processing of numerous FOIL requests.

Executives at several health plans, including Aetna, Excellus BCBS, HealthNow BCBS, HIP, GHI, Independent Health, MVP Health Care, and Oxford/UnitedHealthcare took time out of busy days for enlightening discussions on their companies and the markets and regions in which they operate. IBM's Dr. Craig Weber, SEIU Local 32BJ's Barbara Caress, and officials at POMCO provided much-needed insights on the self-funded market in New York. The many professional agents and brokers to whom we spoke were an invaluable resource, due to their unique perspective on the market.

Bela Gorman of Gorman Actuarial, LLC, provided very helpful comments on portions of this report. The Urban Institute provided the table on income distribution on page 126. Here at the Fund, Research Assistant Jenny Heffernan and former Research Assistant Leslie Powell researched and wrote parts of the section on federal and New York City public employees. Much of the content on state public programs builds on earlier work by Fund colleagues Michael Birnbaum and Danielle Holahan. Andrea Lucas and Miles P. Finley edited *The Big Picture*.

About the Authors

Peter Newell is the co-director of the United Hospital Fund's Health Insurance Project, and the former executive director of the New York State Assembly Committee on Insurance. Allan Baumgarten is an independent research consultant whose work focuses on health care policy, finance, and local market strategies. He is the author of *Minnesota Health Market Review* and has published annual health market reviews in eight other states. For more information, see http://www.allanbaumgarten.com.

Methodology

This report provides a comprehensive profile of New York's public and private health insurance markets. We use the term "market" to include transactions in which buyers pay intermediaries to arrange coverage or cover health care services. Fully insured commercial health insurance markets are surveyed in detail. The self-funded market is reviewed as well, within the limits of available data. State programs such as Medicaid Managed Care and Child Health Plus, and federal programs such as Medicare Advantage and Medicare Part D, are also profiled.

To develop this profile, consultant Allan Baumgarten analyzed 2006 annual statements filed by insurers with the National Association of Insurance Commissioners, and New York State supplements filed with the New York State Insurance Department by domestic insurers and HMOs, also for calendar year 2006. The report's statistical tables for health plan enrollment and financial results are based on those analyses. Mr. Baumgarten also analyzed Medicaid Managed Care Operating Reports filed with the New York State Department of Health to develop similar statistical tables for public programs such as Medicaid Managed Care, Family Health Plus, and Child Health Plus. Finally, he analyzed a variety of data sources from the Centers for Medicare & Medicaid Services to develop statistical data related to the Medicare program.

Peter Newell, who wrote this report, reviewed health plan annual statements, reports on examination of health plans and annual reports of the state Insurance Department Superintendent, Plan-Specific Reports on health plans from the New York State Department of Health, many other reports and data sources made available by the two state agencies, and key statutes, laws, regulations, circular letters, and advisory opinions.

Health plan rating manuals and policy forms, obtained from the state Insurance Department through Freedom of Information Law requests, were a vital source of information. These documents were obtained and reviewed over the course of several months in 2008. Due to the ability of health plans to revise rating manuals and submit new policy forms continuously throughout the year, information in this report may not reflect a company's current practices. Officials at HealthConnect, an online network for buyers and sellers of employee benefits, granted access to their system, which was an extremely helpful tool.

Two key references used were *Group Insurance, Third Edition* (William F. Bluhm, principal editor, 2000, ACTEX Publications, Winsted, CT) and *Essentials of Managed Health Care, Fifth Edition* (Peter R. Kongstvedt, MD, FACP, 2007, Jones and Bartlett Publishers, Sudbury, MA). A report developed by Gorman Actuarial, LLC, and published by the Fund in 2008, *Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools*, was another important reference.

More than 100 individuals were interviewed for this report, including agents, brokers, current and former state regulators and agency officials, legislators, legislative and executive branch staff, lobbyists, trade association officials, health plan executives, and consumers. For a variety of reasons, most of these individuals requested anonymity in order to be able to speak freely. Two former public officials were particularly helpful and insightful: former Insurance Superintendent Sal Curiale, and former

Deputy Superintendent James W. Clyne, Sr.

While comprehensive in scope, *The Big Picture* leaves many issues that warrant further study. For example, payment rates, practices, and methodologies are not discussed here, nor are the reasons for escalating costs of coverage. We also do not delve into relations between health care providers and health plans, which are generally characterized by friction, mistrust, and frustration over rates of payment, payment levels, claims review, and duplicative administrative procedures. And although New York health care consumers generally enjoy strong consumer protection laws compared to those of other states, how they fare in the markets was not explored in this report, nor were the respective quality rankings of individual health plans.

Part I: Overview

In an era of renewed interest in health care reform, nationally and in New York, the goal of this report is to help policymakers and the New Yorkers they represent decide on the type of health insurance system they want, by informing them of how our health insurance markets work today and of the possible impact of federal reform on our local markets. To that end, *The Big Picture* presents a comprehensive profile of public and private markets — the buyers, sellers, products, health plan financial results, how the markets are organized, and the key laws, regulations, and events that shape them. Medicaid and Medicare fee-for-service programs are not reviewed in this report, as the focus is on discrete markets in which buyers contract with intermediaries to arrange coverage or transfer risk.

Health insurance — particularly commercial health insurance — is extremely complex. Much of that complexity derives from health plans' desire to differentiate themselves from their competitors — traditionally accomplished through segregating risk and pricing it accordingly, but of late through diverse and complicated cost-sharing mechanisms. While every effort was made to make the markets' functions more easily understandable, some complexity was unavoidable.

No effort is made in this overview to summarize the material in a report with so broad a sweep, nor is the object prescriptive. Instead, a few central themes that emerged are identified, beginning with that very complexity of the markets, and the implicit question that follows of what value it adds.

Health Plan Organization

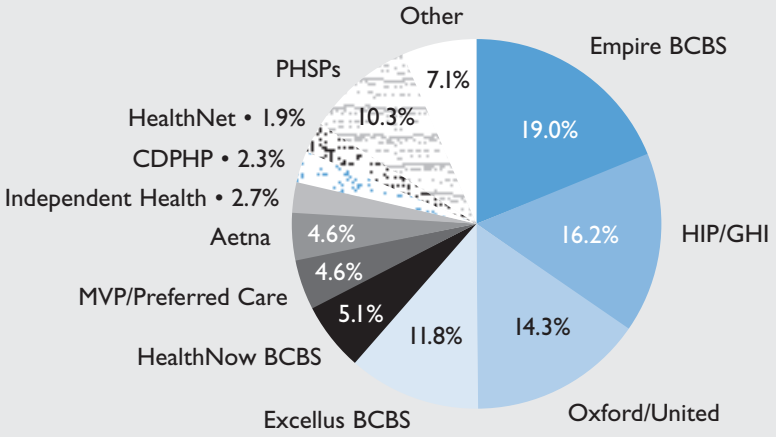
Buyers in New York State's health insurance markets — individuals, businesses, and government — paid health plans over $41.5 billion in premiums for insurance coverage in 2006. In addition, businesses self-funded health coverage for over 4.5 million workers, spending billions more on medical claims and fees to plan administrators.

After an era of consolidation in New York and nationally, four health plans — Excellus, Empire BlueCross BlueShield, Oxford Health Plans/UnitedHealthcare, and Health Insurance Plan of New York/Group Health Incorporated (HIP/GHI) — collected nearly two-thirds of those premiums (Figure 1). But New York's "Big Four" joined that exclusive club in slightly different ways. Empire is a leader in commercial enrollment, with solid enrollment, too, among public employees, but is not a player in New York's largest public programs. Oxford/UnitedHealthcare is active in both public and private markets, as is Excellus. HIP/GHI, also known as "EmblemHealth" since the two companies affiliated under a common board in 2006, boasts strong public program enrollment, but much of its commercial enrollment is concentrated among public employees.

Reflecting the growing importance of public programs in New York — and their own strong position in these markets — the collective premium share of Prepaid Health Services Plans (see Appendix A for a glossary of health plan terms) amounted to over 10 percent of total premiums in 2006.

In another sign of consolidation in the

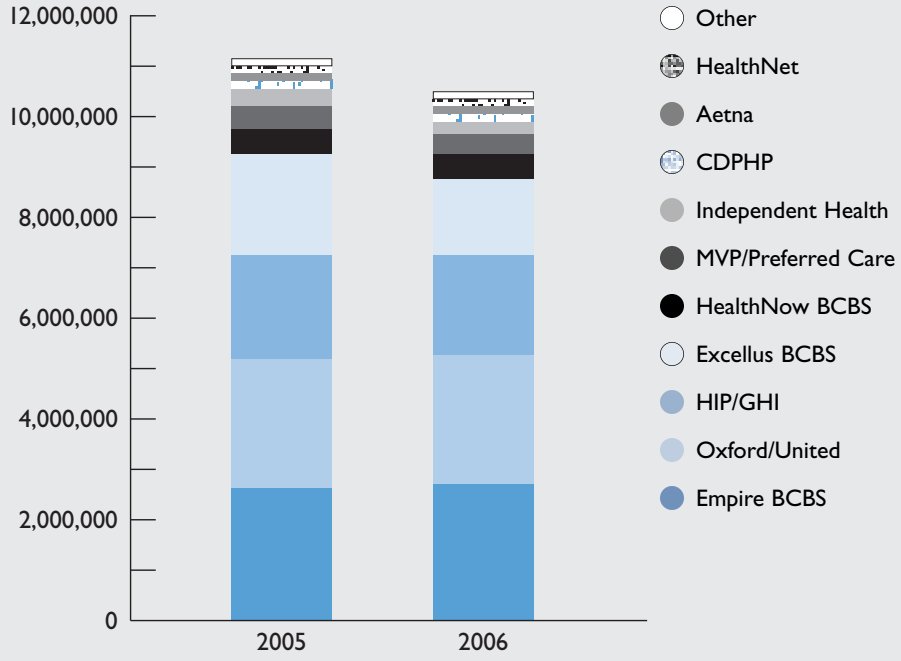
Figure 1. **Health Plan Market Share Based on Premiums, 2006**



Note: 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.

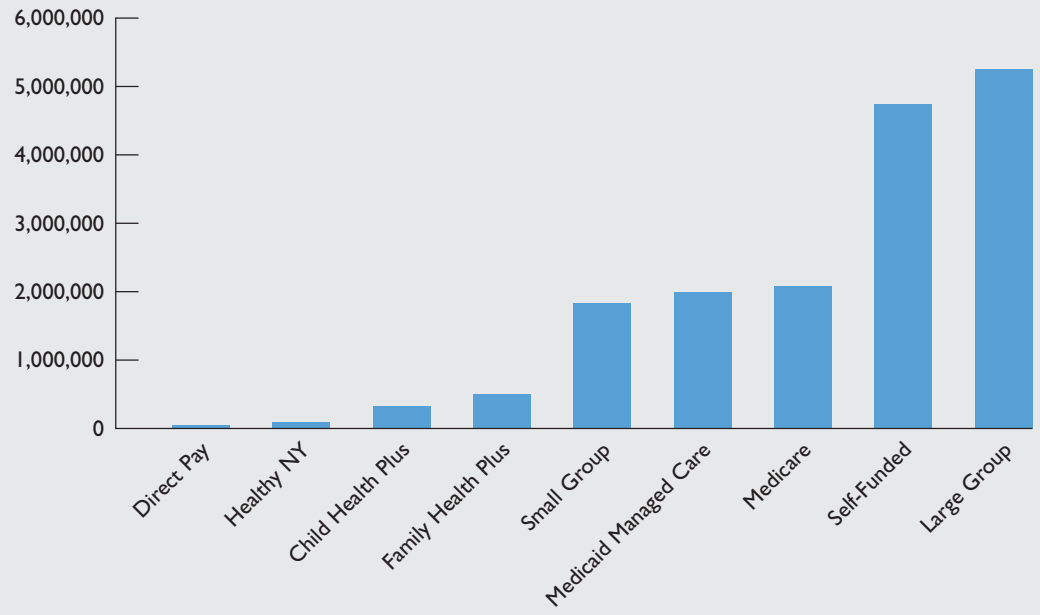
Source: Author's analysis of health plan annual statements, Exhibit of Premiums, Enrollment and Utilization; for national insurers, NAIC annual statement, Schedule T, premiums collected in New York State; for PHSPs, Medicaid Managed Care Operating Reports filed with the state Department of Health.

Figure 2. **Employer Group Enrollment, 2005 and 2006**



Source: Author's analysis of health plan annual statements. Includes enrollment in commercial groups, Article 43 Provider Service Organizations, PPOs and Indemnity Only, and Life, Accident and Health company group comprehensive.

Figure 3. **New York State Public/Private Market Segment Enrollment**



Note: Large Group commercial group enrollment adjusted by United Hospital Fund to reflect duplicate reporting by health plans. Medicare enrollment includes Medicare Advantage, Medicare Supplemental, and Medicare Part D drug coverage, but not fee-for-service Medicare. Medicaid Managed Care enrollment does not include fee-for-service Medicaid.

Source: Enrollment figures in this report; estimates of self-funded enrollment from Part III are based on Agency for Healthcare Research and Quality Medical Expenditure Panel Survey data.

commercial market, the Big Four accounted for over 80 percent of commercial group enrollment (Figure 2); Empire and Oxford/United each had about a 25 percent share of the 10.6 million-member market.[1] From many perspectives, New York has always been an "upstate vs. downstate" state, and that's well illustrated in health plan enrollment. New York's upstate market is dominated by nonprofit plans such as Excellus, HealthNow, Capital District Physicians Health Plan (CDPHP), Independent Health, and MVP/Preferred Care, while downstate markets contain a larger share of for-profit national plans. For-profit and nonprofit health plans split commercial enrollment almost equally (53 percent to 47 percent) in New York markets, an equation that would change if HIP/GHI converted to for-profit status.

New York State's commitment to expanding coverage through public programs is demonstrated by the size of those programs, compared to segments of the commercial market. Enrollment in Medicaid Managed Care now comfortably exceeds the size of New York's Small Group market (Figure 3). When combined with two other public programs, Family Health Plus and Child Health Plus, the state public program market exceeds the Small Group and Direct Pay markets by almost one million covered lives. While the Large Group commercial market is still the biggest segment in New York, enrollment in three main public employee programs accounts for over a third of total Large Group enrollment. Note, however, that since health plan group enrollment is reported based on

[1] Total reflects out-of-state residents enrolled through businesses in New York State, and some overcounting due to health plan reporting methods and some employer groups receiving joint delivery of comprehensive benefits by more than one health plan.

where companies are located and not where employees live, New York commercial market figures capture significant enrollment from out-of-state workers.

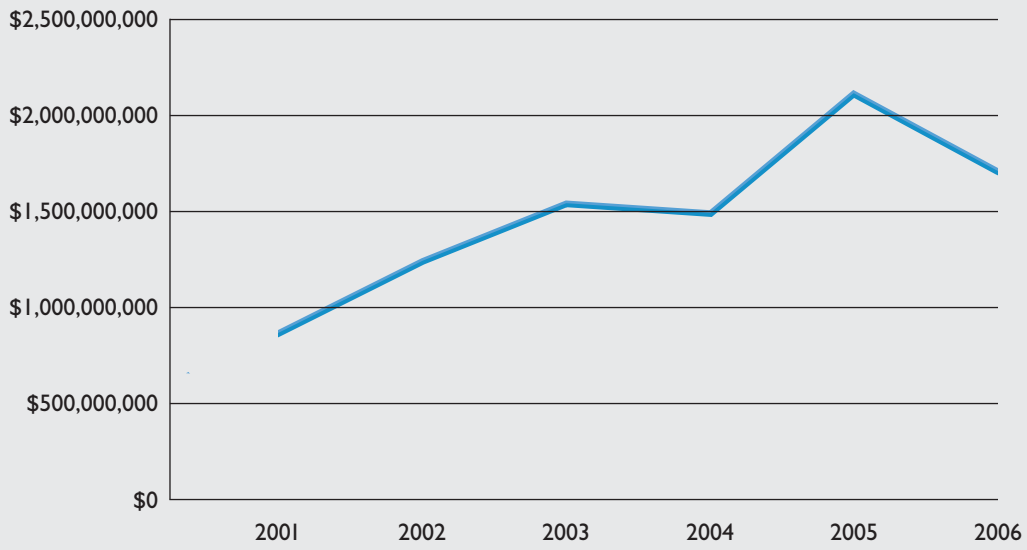
Plan Finances

Despite declining enrollment in commercial markets, health plans had an extraordinary run of profitability, beginning in the late 1990s and continuing through 2006. Seven major health plans — Aetna, Empire, Excellus, HealthNow, HIP/GHI, MVP, and Oxford/United — earned over $1.6 billion in profits alone (Figure 4), and almost all health plans accrued surpluses or net worth far in excess of state solvency standards. There are signs, however, that the era of record profits may have come to an end. Excellus, for example, the largest health plan upstate, posted profits of less than $100 million for 2007, the bulk of it from investment income, and $54 million in losses in 2008.[2] As investment returns and enrollment at health plans continue to decline in the midst of a deep recession, United Hospital Fund plans to publish a special update on health plans' 2008 enrollment and financial results later in 2009.

Industry watchers have been divided over whether these declines signaled the start of a new "underwriting cycle," the tendency of the health insurance industry's profitability to go through boom and bust phases at regular intervals. During good times, analysts praise health plans' "pricing discipline," in which premiums reflect anticipated medical expenses plus a healthy profit margin. In lean years, health plans "guess wrong" on medical costs, or sacrifice profitability to increase market share. Whatever the case, the single largest

[2] Mulder J. February 27, 2009. Excellus loses $54 million in 2008. *Syracuse (NY) Herald Journal.*

Figure 4. **Net Income for Largest Health Plans, 2001 to 2006**



Note: Companies included are Aetna, Empire BCBS, Excellus BCBS, HIP/GHI (EmblemHealth), HealthNow BCBS, MVP Health Care, and Oxford/United companies. Results for separately licensed subsidiaries operating in New York under a common parent company are combined.

Source: Author's analysis of health plan annual statements and New York Supplements.

factor in health plan profitability of late has been the explosive growth of enrollment and profit in the Medicare program.

Medicare Profits

In 2003, changes in federal Medicare laws increased reimbursement and expanded products for Medicare-eligible beneficiaries. As a result, health plans posted major profits in their Medicare business, particularly through Medicare Advantage programs offered to individuals or employer groups as an alternative to traditional or fee-for-service Medicare and company-sponsored retirement plans. New York health maintenance organizations (HMOs) posted over $400 million in profits on their Medicare Advantage business, which provided an average of over 40 percent of the profits from all lines of health plans' business — and as high as 80 percent for some HMOs. Amid mounting concern about the gap between Medicare Advantage and traditional Medicare rates, in late 2008 Congress administered a $10 billion "haircut" to Medicare Advantage rates, to avert provider reimbursement cuts. The Centers for Medicare & Medicaid Services announced a new round of Medicare Advantage cuts of between 4 and 5 percent in April 2009.[3] With future reductions considered likely, payment decreases could pose bottom-line concerns for health plans, solvency issues for those health plans heavily dependent on Medicare Advantage income, and greater out-of-pocket costs for Medicare enrollees purchasing these products.

To a lesser degree, New York State public programs also bolstered health plans' bottom lines, but returns were far less healthy than in the Medicare market. For-profit Prepaid Health Services Plans (PHSPs) with national operations (Amerigroup, for example), and subsidiaries of national health plans (such as AmeriChoice, part of UnitedHealth Group) were profitable, but members of New York's robust nonprofit PHSP sector — Affinity, HealthFirst, HealthPlus, and Fidelis, for example — reported the highest net income in 2006 among PHSPs.

The "Hollowing Out" of HMOs

In an analysis with lots of numbers, among the most striking was the decline in enrollment in traditional HMO coverage, which offers comprehensive benefits in exchange for use of network providers, managed through a primary care gatekeeper.

As a result of both pushback against managed care models and New York's regulatory scheme, commercial enrollment in traditional HMOs dropped 37 percent (almost one million enrollees) from December 2004 to June 2008, a shift replete with implications for health care policy in New York.

While the transfer of business from one corporate entity to another is no cause for great concern in and of itself, in New York it is being accompanied by benefit reductions and increased cost-sharing, as health plans look to put health care inflation somewhere else besides the premiums employer groups pay. Once the "daily special" available to employer groups, comprehensive HMO coverage is becoming one of the most costly entrées on the menu. And as commercial market enrollees self-select from a range of benefit options, higher-risk groups are staying put in comprehensive plan designs, while lower-risk groups are moving to designs with increased cost-sharing.

In addition to these market issues, the decline of HMO coverage has systemic implications. Consumers and health care providers have chafed at managed care's strictures and the consequences of clumsy execution; if an HMO death notice appeared in the newspaper, many would cheer. But the model does offer systematic collection of

[3] Fuhrmans V and G Zhang. April 7, 2009. U.S. reduces subsidies for private Medicare. *Wall Street Journal.*

quality data, low financial barriers to accessing care, and comprehensive benefits. At a time when health care experts call for increased emphasis on primary care, "value-driven" benefits packages, increased use of information technology and quality measurements, and payment methodologies that reward coordination of care through integrated networks, the decline of HMOs is perplexing. Although staff model HMOs, which offer the highest level of coordination, have all but disappeared in New York, and most HMOs are not significant users of capitation (see Table 18, page 75; only three plans reported significant use of capitation), they are characterized by an infrastructure that can support these reforms. But most HMOs now tout benefit designs without gatekeepers and use fee-for-service payment methodologies.

"The silo effect" is an overused term, but it certainly applies to New York's regulation of public and private insurance markets. While traditional HMO coverage is disappearing in the commercial market, it remains the cornerstone of New York public programs. And while employer groups face a dizzying array of benefit designs, New York provides essentially one benefit package, with minor variations, to its Family Health Plus, Child Health Plus, and Medicaid Managed Care enrollees.

Recent developments, however, will test New York's dual-track regulations and policies — *and* provide some new opportunities. Enactment of the Family Health Plus (FHP) buy-in legislation, which allows employer groups and labor unions to purchase group FHP coverage, and discussions of a statewide exchange or "connector," for example, are forcing New York to think about integrating public and private markets. The growth of public programs has created a dynamic in which enrollment shifts from the private market to public programs, where many of the same health plans get another bite of the apple.

Yet the two regulatory systems rarely overlap. As state officials work to implement a number of reimbursement reforms and technology and quality improvement measures across public markets, commercial health plans are working independently and without coordination to develop quality-related products that are, for the most part, proprietary.

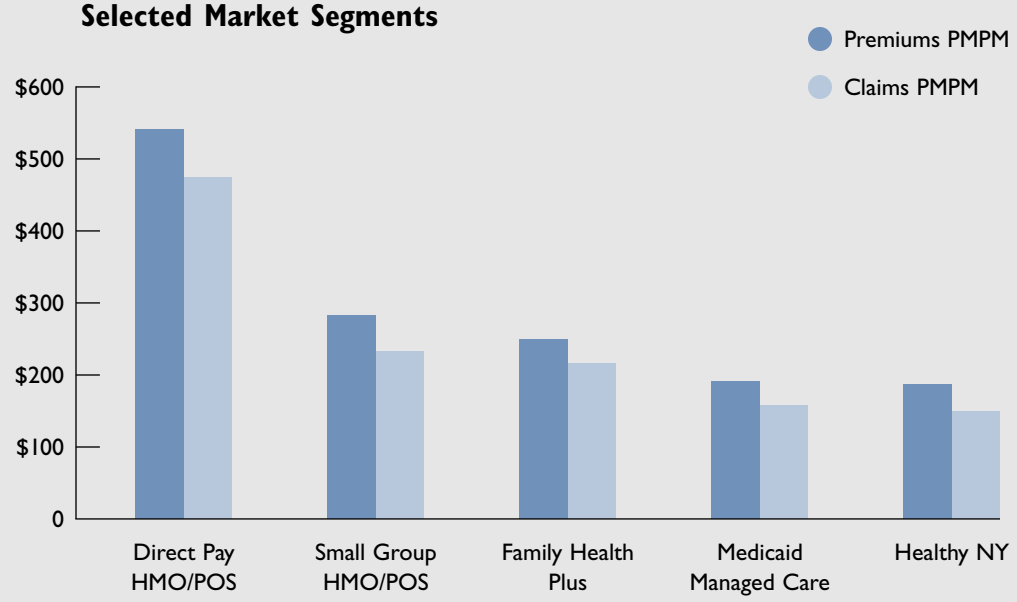
Analysis of premiums and claims data for public and private markets (Figure 5) suggests that New York will also need to confront the issue of the relative efficiency of various markets. Reimbursement practices, separate provider networks for public and commercial enrollees, and benefit variations no doubt account for some differences, but New York delivers a comprehensive benefit package to Medicaid Managed Care enrollees, for example, at about the same premium that employer groups and individuals pay for Healthy NY coverage. When the roughly $70 monthly in Healthy NY stop-loss subsidies are added to the premium, there is little difference between Family Health Plus premiums (for its comprehensive benefit package) and Healthy NY costs. New York also pays less for FHP coverage than the typical Small Group market premium. The level of monthly claims in both the FHP and Medicaid Managed Care programs suggests that integrating these members with new members who enroll in any coverage expansion should be further considered.

Looking Ahead

State policymakers have made significant headway on the public program side, with fully engaged efforts to simplify enrollment, standardize and increase eligibility, streamline rate-making, adjust for risk, and improve quality. State budget problems loom large, however, eased this year through increased federal Medicaid support.

On the commercial side, there is some

Figure 5. **Premiums and Claims Per Member Per Month, Selected Market Segments**



Source: For Direct Pay, Small Group, and Healthy NY, Gorman 2008; for Family Health Plus and Medicaid Managed Care, 2006 Annual Plan Statewide Reported Profit and Loss Analysis, New York State Department of Health.

unfinished business. New York's landmark Community Rating/Open Enrollment law, which governs the individual and Small Group markets, has weathered well for small employers and Healthy NY subscribers, but is badly broken for direct purchasers. While the market rules have preserved access to quality coverage for all individuals regardless of age, sex, health status, or occupation, a failed pooling mechanism and inadequate subsidies make the market unaffordable to many. In a sign of the uneasy co-existence of two rating systems — community rating and experience rating — gender and occupation still play a factor in experience-rated markets, in the rates paid by employer groups of between 51 and 150 employees, many readers may be surprised to learn.

The overriding picture that emerges in the commercial sector is that of a "stressed-out" market, reeling from years of double-digit premium increases. Increased cost-sharing, the chief tool that has emerged to blunt inexorable cost increases, is creating challenges for consumers, health care providers, and regulators. Even the most fundamental element of risk spreading — the employer group — has begun to fray, as cost-sharing helps offset premium increases for the whole group but shifts more costs to users of more services within the group.

This report is organized in four parts: commercial insurance, the self-funded market, New York State public insurance programs, and Medicare. We begin the discussion of the commercial market at the place where insurance regulation begins, the licensing of different types of health plans.

Part II:
The Commercial Market

The Sellers

Licensees: Article 42s, 43s, 44s, and PHSPs

While we use the term "health plans" to apply to all kinds of health insurers, individuals and groups buy fully insured health benefits in New York State through four distinct kinds of entities, referred to most commonly by the article of the New York Insurance Law or Public Health Law under which they are licensed: Article 42, 43, or 44 companies, and PHSPs (Prepaid Health Services Plans).

Since insurance is state-regulated but many national companies operate in multiple states, a system has evolved in which states have greater regulatory control over "homegrown" insurers, known as "domestic" companies, but license "foreign" health plans, domiciled in other states, to operate.

Article 42s. Article 42 of the New York Insurance Law provides for the operation of "Life Insurance Companies and Accident and Health Insurance Companies." Also referred to as "commercial insurers" or "A&H" companies, Article 42s are organized as stock or mutual companies, and licensed to sell "accident and health insurance," one of thirty-two separate lines of insurance coverage authorized for sale under the law, and defined as "insurance against death or personal injury by accident or by any specified kind or kinds of accident and insurance against sickness, ailment or bodily injury."

Until recently, this regulatory space was occupied exclusively by life insurance companies such as MetLife, New York Life, and the Guardian, which added health insurance products to the life and annuity products they marketed to employer groups and individuals, using the same underwriting techniques. The A&H line of business includes disability insurance and more arcane offerings such as accidental death and dismemberment insurance, indemnity products that pay fixed cash amounts. Most of the laws governing health insurance contracts, benefits, and rate increases for for-profit health insurers are contained in Article 32 of the Insurance Law. The State Insurance Department (SID) oversees twenty-nine Article 42s selling accident and health insurance in New York. Today, many Article 42 companies are part of large holding company structures that include other types of health plans.

Article 43s. Article 43 of the Insurance Law, governing the operations of "Non-Profit Medical and Dental Indemnity" or "Health and Hospital Service Corporations," was added in 1934 with the establishment of the first New York Blue Cross hospital plans and, later, the Blue Shield physician services plans. New York State's early HMOs, such as HIP, and nonprofit prepaid health plans, such as GHI, were also organized under the umbrella of Article 43. These nonprofit health plans are also known as HMDIs — Hospital, Medical, and Dental Indemnity companies.

Insurance Law Article 43 sets out tax exemptions for licensees, special requirements for provider and enrollee participation on boards of directors, limitations on expenses, minimum surplus requirements, and regulations on rate increases and benefits. Though largely self-contained, the article references provisions in Article 42 related to group eligibility standards, reimbursement for

providers such as dentists, physical therapists, chiropractors, and podiatrists, and other provisions in the Insurance Law related to permitted investments.

After a series of mergers in the last decade, only four Article 43 health insurers marketing comprehensive health insurance coverage remain: HealthNow, the Buffalo-based Blue Cross Blue Shield plan; Excellus, the Rochester-based Blue Cross Blue Shield plan; and HIP and GHI, which operate as affiliated companies under the parent company EmblemHealth, a 501(c)(3) organization with a governing board made up of an equal number of representatives from each of the plans. HIP and GHI hope to convert to a single for-profit corporation and surrender their Article 43 licenses soon. Empire BlueCross BlueShield surrendered its Article 43 license when it converted to for-profit status, but continues to operate as a Blue Cross plan downstate through its two for-profit licensees.

Article 44s. Article 44 of the Public Health Law provides a comprehensive scheme for the operation of HMOs. While the Insurance Law[4] provides a limited exemption from licensing for Article 44s, it also contains a list of twenty-five specific Insurance Law provisions that apply to their operations. Article 44 authorizes the Health Commissioner to issue HMOs "certificates of authority" and renewals. But regulatory authority over the entities is shared with the SID.

Generally, the Department of Health (DOH) is the primary regulator of HMO service areas, provider networks, quality issues, compliance with Public Health Law provisions concerning, for example, character and competency reviews of plan sponsors, and consumer protections. It also exercises oversight of the contracts health plans enter into with providers and affiliates. The SID oversees health plan solvency and minimum capital requirements, rates, the contracts and policies issued to groups and individuals, including required benefits, and Insurance Law provisions. On many areas, such as reconciling state-mandated benefits with the Article 44 requirement that HMOs offer "comprehensive health benefits plans" to enrollees, the two agencies must work in tandem. Some states (New Jersey, for example) have created single agencies to regulate all types of health plans, but New York has not, a source of irritation at times for the industry. In 2007, nineteen HMOs offered products to commercial populations across the state.

Prepaid Health Services Plans (PHSPs). A Prepaid Health Services Plan is a type of HMO with a special limited certificate of authority from the Health Commissioner. Although PHSP provisions go back to 1984, enrollment in the plans took off with the move to mandatory Medicaid Managed Care enrollment. Today, many of the largest PHSPs are sponsored by hospitals.

The PHSP statute has been renewed and revised periodically. Earlier versions of the law exempted PHSPs from more stringent solvency standards and contract and employer group requirements. At present, most of the distinctions between HMOs and PHSPs have been eliminated or are being phased out, except for provisions that limit PHSP enrollment of commercial members to 10 percent of total enrollment.

Currently, the Department of Health has the authority to license eighteen PHSPs; most of the largest ones are hospital-sponsored. In 2007, fifteen PHSPs enrolled public program members.[5] With the growth of public programs, enrollment in PHSPs such

4 NYIL Section 1109.

5 Ibid.

as HealthFirst and Fidelis now approaches enrollment levels at full-service HMOs upstate. Other PHSP licensees include Wellcare and Amerigroup, for-profit national corporations that are publicly traded.

Postmodern Era

In the current "postmodern" era of health plan regulation, for-profit and nonprofit health plans deliver benefits from large holding company structures with multiple licensees. UnitedHealth Group operates in New York through its Oxford and UnitedHealthcare Article 44 and 42 licenses, four of about 250 subsidiaries within the holding company.[6] Empire BlueCross BlueShield's Article 44 and Article 42 licensees are just two entities in three pages of postage stamp-sized subsidiaries controlled by the Wellpoint, Inc., holding company.[7]

Nonprofit health plan holding companies are not as large but are similarly complex. A 501(c)3 foundation sits on top of the EmblemHealth corporate structure, with stacks of subsidiary for-profit and nonprofit insurance licensees from New York, Connecticut, and Massachusetts, and taxable and non-taxable holding companies below, organized in relation to the two main insurers that affiliated to create the new company, HIP and GHI. Lifetime Health Care Companies, the parent of Excellus Blue Cross Blue Shield, includes Article 43 licensees, for-profit long-term care insurers, HMOs operated as a "line of business" through the Article 43 license, home care agencies, third-party administrators, insurance brokerages, and a reinsurer.[8]

Even smaller regional insurers have multiple licenses. Schenectady-based nonprofit MVP Healthcare operates through its HMO license, an Article 43 license, and an Article 42 license; Albany-based nonprofit CDPHP does business though its Article 43 and Article 44 licenses. The holding company structure for HealthFirst includes the HealthFirst PHSP license, as well as an HMO subsidiary offering commercial coverage, and growing Medicare Advantage enrollment in New York and New Jersey.

While other commentators have noted the "hollowing out" of HMOs due to the relinquishing of managed care functions,[9] the migration of business from HMO licenses in New York is also a byproduct of unresolved tension in the regulatory scheme. State regulators seek to preserve comprehensive products for New York customers in an era of increased cost-sharing and struggle to hold HMOs to their original promises. They view the "flexibility" HMOs seek on benefit design as simply more cost-sharing. In a pointed reminder of the high expectations for HMOs at their infancy, state law still requires larger employer groups to offer HMO coverage to workers.[10]

Meanwhile, HMO officials — chafing at what they feel is unfair and rigid treatment that gives competitors with other licenses an advantage and puts HMOs at risk of adverse selection — call for the elimination of the differences between HMOs and other licensees (see Table 1). As usual, regulators face a difficult decision: allow Article 44s to act like other licensees, make other licensees act like Article 44s, or continue to watch the inexorable outflow of business to the less highly regulated licenses.

Like any business organization, health plans are adept at analyzing a regulatory scheme and making it work for them in the market. HMOs organized under Article 44 are "voting with their feet" and moving business to other licenses. In the mid-1990s,

6 Oxford Health Insurance, Inc. 2006. Annual statement, Schedule Y.

7 Empire HealthChoice Assurance, Inc. 2006. Annual statement, Schedule Y.

8 Robinson JC. March-April 1999. The future of managed care organization. *Health Affairs* 18(2):7-24.

9 Ibid.

10 NYPHL Section 4407.

Table 1. **Health Plan Licensing Requirements**

Issue	Article 44s	Article 43s	Article 42s
Commissions	4% Limit	Unlimited	Unlimited
Deductibles	Not permitted in network	Unlimited	Unlimited
Co-pays	Limited	Unlimited	Unlimited
Administrative Expense	15% cap	15% cap	Unlimited
Large Group Community Rating	Required for traditional HMO products	Optional	Optional
Mandatory Markets	Direct Pay, Small Group, Healthy New York	None	None
Minimum Participation	Not permitted in Small Group	Permitted	Permitted
Quality Reporting	Extensive, all markets	HMO line of business, and some PPO reporting	Some PPO reporting

Source: UHF analysis of New York State Insurance Law and Public Health Law provisions, and accompanying regulations.

HMOs losing market share to less tightly managed products created new "Point of Service" hybrids, providing the out-of-network benefit through an Article 42 subsidiary (known as "writing it on commercial paper"). Today, health plans market "managed care look-alike" products issued through Article 43s or Article 42s.

State lawmakers have moved to bring some of the trappings of HMO regulation to these newer managed care look-alike designs. New York's landmark 1996 Managed Care Consumer Bill of Rights[11] applied some provisions of the laws governing HMOs to non-HMO "managed care health insurance contracts." Consumer and health care provider protections were expanded somewhat in 2007,[12] and the legislature and Governor agreed on a further expansion in 2009.[13]

While some drop-off in HMO enrollment can be attributed to the long-standing market pushback against managed care, and interest from employer groups in less costly benefit designs, dramatic declines in HMO enrollment lately in New York suggest that other forces are at work. In 2006, HMO enrollment dropped by 100,000. Some companies lost HMO members, but gained significant enrollment in their Article 42 or Article 43 licensees. Between December 2006 and March 2008, enrollment in comprehensive HMO products declined by over 500,000 members, from 2.2 million to 1.7 million.[14]

11 Chapter 705 of the Laws of 1996.

12 Chapter 451 of the Laws of 2007.

13 A.8402-A/S.5472-A of 2009.

14 New York State Department of Health. December 2006 and March 2008. Quarterly enrollment reports. Albany: New York State Office of Managed Care.

Cigna announced plans to exit the New York HMO market in 2008, and Long Island-based HMO MDNY entered liquidation in 2008, with its officials attributing its demise to the inability to offer experience-rated products.[15] The retiring CEO of Albany-based CDPHP, an HMO with an Article 43 license, recalled that when he took the helm at the plan, customers were using CDPHP to insure their sick employees and giving the healthy ones cheaper policies from other companies. "We were the health insurer of last resort," he noted. "We were in an HMO death spiral."[16]

Consolidation and Conversion

For decades, mergers and acquisitions in New York were limited largely to mostly amicable "marriages" between Blue Cross and Blue Shield plans, yielding single corporate entities. That changed in the late 1980s as large life insurers sought to buy in to the growing managed care movement, then accelerated in the mid-1990s as for-profit national insurers entered the New York market and nonprofit health plans began making the same strategic decisions as their for-profit competitors. The most recent wave of mergers has reshuffled the Medicaid market (see "Consolidation and Conversions in New York," pages 14-15).

Depending on the nature of the transactions and the corporate structure of the licensee involved, "changes of control" (the term state regulators use to describe a variety of transactions, including conversions, mergers, affiliations, and acquisitions) are governed by a handful of statutes and regulations: the New York Not-for-Profit Corporation Law, Articles 15 (Holding Company Act), 43 (Non-Profit Health Plans), 71 (Mergers, Consolidations), and 73 (Conversions) of the Insurance Law, and Article 44 of the Public Health Law. Final approval of a change of control can involve insurance and health departments from multiple states, antitrust officials from the Attorney General's Office and the U.S. Department of Justice, officials from the Attorney General's Charities Bureau, and review by New York State Supreme Court justices.

New York's "user-friendly" Holding Company Act governs most mergers of for-profit companies, and prohibits the Insurance Superintendent from disclosing documents filed with merger applications "without the prior written consent of the controlled insurer to which it pertains unless the superintendent after notice and opportunity to be heard shall determine that the interest of policyholders, shareholders or the public will be served by the publication thereof."[17] Often the only public information available regarding multi-billion-dollar transactions affecting millions of insured people and thousands of providers are brief letters outlining the terms and conditions of the agreement after it is approved by regulators.[18]

Conversions of nonprofit companies to for-profit entities, such as that proposed for HIP and GHI, undergo a more public review. Under the statute, the Superintendent may approve a conversion if it "will not adversely affect the applicant's contract holders or members, will protect the interest of and will not negatively impact the delivery of health care benefits and services to the people of New York, and results in the fair, equitable and convenient winding down of the business and affairs of the applicant."[19]

In January 2008, New York State Insurance Department officials conducted two public

15 Benson B and G Scott. December 12, 2007. End of an era for doc-owned HMO. *Crain's Health Pulse.*

16 Wechsler A. June 29, 2008. More than just a physician. *Albany Times Union*, C1.

17 NYIL Section 1504(c).

18 For example, re UnitedHealth Group's $4.8 billion acquisition of Oxford Health Plans, correspondence from Insurance Superintendent Gregory V. Serio to Dr. William W. McGuire, chairman and chief executive officer, UnitedHealth Group, Inc., dated July 20, 2004.

19 NYIL Section 7317(b)

hearings, in New York City and Albany, on the proposed HIP/GHI conversion. The two organizations have been operating as separate companies under a common board of directors as a result of an affiliation agreement approved in October 2006.[20] The City of New York has sued to block the conversion on antitrust grounds, but in May 2009 the company and the Insurance Department agreed to suspend discussions, given adverse financial market conditions.

As is the case nationally, merger activity has changed the health care landscape in New York. The six Blue Cross Blue Shield regions of 1990 have dwindled to just three, and smaller regional HMOs have, for the most part, combined, been acquired, or failed. Much of the merger/acquisition activity has occurred in the downstate market, now dominated by for-profit health plans, while the upstate market remains firmly nonprofit, but with fewer companies.

For-profit conversions have been blunted by the limited applicability of state conversion legislation. Legislation adopted in 2002 was drafted to permit only Empire to convert; legislation authorizing HIP and GHI to convert in 2006 was drafted with reference to the Metropolitan Transportation Authority service area, in order to limit the bill's effect to the two companies. While some upstate health plans have publicly contemplated conversion, they have worked lately to limit the ability of for-profit companies to enter the upstate market through acquisition of a nonprofit plan.

The effect of consolidation on New York health care providers and consumers is a complicated one, and will not be resolved here, but some observations can be made. One recent national study of the effect of consolidation divided New York State into two markets, upstate and down-, and found "moderate" concentration compared to other states, using U.S. Department of Justice guidelines.[21] An annual survey of concentration produced by the American Medical Association[22] analyzes regional markets in terms of market share of HMO and PPO products, using Department of Justice tools such as the Herfindahl-Hirschman Index. The survey shows that it is difficult to draw definitive conclusions about market conditions from an overhead view. (See Appendix B for a description of regional commercial insurance markets.)

Geographic definitions of market regions — just where the boundaries of a market begin and end — can skew conclusions on market share. Analyses that do not include information on self-funded arrangements in the market are incomplete, and the manner in which health plans report enrollment, particularly for public employees, is challenging, to say the least. For Binghamton, in New York's Southern Tier, for example, the AMA study cites Empire as the dominant PPO plan, but other than for state workers covered through the Empire Plan (who are serviced by the local BCBS plan, Excellus), Binghamton is outside of Empire's service area. For Buffalo and two nearby towns, the AMA study attributes 88 percent and 12 percent HMO market shares to HealthNow and Excellus, respectively, and no market share at all to Independent Health, which competes toe-to-toe with HealthNow for market share in the larger, eight-county Buffalo region, with over 200,000 fully insured commercial members.

As health plans like to point out, market share concentrations can be good for health insurance purchasers, if market power is used to drive down costs and pass on savings to

20 New York State Insurance Department. n.d. HIP/GHI plan of conversion documents. http://www.ins.state.ny.us/hip_ghi_conv/hip_ghi_planof.htm.

21 Robinson 1999. [Note 8]

22 *Competition in health insurance.* 2007 update. Chicago: American Medical Association.

Consolidation and Conversions in New York: An Informal History

1985

- Blue Cross of Northeast New York and Blue Cross of Greater New York merge to form Empire BlueCross BlueShield.

1987

- Blue Shield of Western New York merges with Blue Shield of Northeastern New York.
- New York Life acquires the managed care company Sanus.

1989

- Equicor, a joint venture of Equitable Life Assurance and Hospital Corporation of America, acquires Long Island-based Total Health Systems, Inc.

1990

- Cigna acquires Equicor.

1992

- Blue Cross of Western New York and Blue Shield of Western New York merge to create a single plan incorporating both the western and northeast regions of the state.

1994

- Travelers and MetLife merge their health units to form Metra Health. With 13 million members, the combined company is for a time the largest in the U.S.

1995

- Minnesota-based UnitedHealth Group buys Metra Health and, by doing so, takes over administration of outpatient health benefits for hundreds of thousands of state and local government workers covered by the state's Empire Plan.

1996

- Hartford-based Aetna and Philadelphia-based U.S. Healthcare merge and, with 23 million covered lives nationally, become the country's largest health plan.

1998

- Kaiser Permanente HMO and Community Health Plan (CHP) merge. The merger with the small eastern division of the California giant is not enough to rescue CHP, a venerable Albany-based staff-model HMO; most of its business is sold the following year to Capital District Physicians Health Plan and the company is liquidated by state regulators in 2007.
- Aetna acquires NYLCare, the HMO subsidiary of New York Life, as another domestic life insurer gets out of the health insurance business.
- Rochester-based Excellus Blue Cross Blue Shield merges with the Utica-Watertown Blue Cross Blue Shield plan, creating a large service area south and east of its home base in Rochester.

1999

- Group Health Inc. (GHI) opens up an HMO and acquires the commercial business of the Well Care Management Group, an HMO based in Kingston, NY, that had teetered on the edge of insolvency.
- Aetna acquires Prudential HealthCare, the health care business of Newark, NJ-based Prudential Life Insurance Company, and a significant player in New York's market.

2000

- Excellus merges with its sister Blue Cross Blue Shield plan in Syracuse and central New York, expanding its service area to 31 counties.
- Cigna acquires the HMO Health Source of New York.

2001

- Excellus merges with Buffalo-based Univera, the successor to Health Care Plan, Inc., an HMO begun in the 1970s. The merger strengthens Excellus's presence in central New York, where Univera has an HMO subsidiary, and allows it to compete with the western New York Blue Cross plan HealthNow. Following approval of the

merger, Excellus becomes the second largest insurer in New York State. The Community Health Foundation of Western New York is created as part of the deal.

- Health Insurance Plan of New York (HIP) acquires Vytra, the Long Island-based HMO started by a local hospital and Buffalo-based Univera.

2002

- Empire BlueCross BlueShield's conversion to for-profit WellChoice is approved by regulators. A new charitable foundation, the New York State Health Foundation, is created pursuant to the enabling legislation. The New York State Court of Appeals dismisses a lawsuit filed in 2005 by consumer groups challenging the conversion.
- UnitedHealth Group announces plans to acquire Americhoice.

2004

- UnitedHealth Group merges with Oxford Health Plans, after talks between Empire and Oxford break down earlier in the year.

2005

- Indianapolis-based Wellpoint, the giant for-profit Blue Cross/Blue Shield plan, acquires Empire BlueCross BlueShield, which had converted to for-profit status in 2002, and proclaims itself the largest health plan in the U.S., with 34 million members. In a unique transaction, Wellpoint negotiates the deal with representatives of the majority stockholder of Empire BlueCross parent WellChoice — the State of New York's Public Asset Fund — which held 80 percent of the shares under the legislation that authorized Empire's conversion.
- Schenectady-based MVP Health Care and Rochester-based Preferred Care merge, creating a company with over 800,000 covered lives and a service area extending from Rochester south through the Southern Tier and east through the Hudson Valley, the Capital District, and Vermont. The merger results in the creation of the Greater Rochester Health Foundation, seeded with $200 million.
- HIP acquires Connecticare, the Connecticut-based for-profit HMO that's one of Connecticut's largest, covering members in Massachusetts as well.
- HIP and GHI reorganize into an affiliation structure in which a new parent holding company, EmblemHealth, with an equal number of board members from each company, manages the new enterprise. While the two companies continue to operate as separate business units, company officials celebrate the creation of the "largest health insurer based in New York State," with over four million members and $7 billion in revenues.
- Amerigroup, a national, publicly traded health plan, acquires CarePlus, a New York PHSP.

2006

- HIP acquires PerfectHealth Insurance Company, the Staten Island-based, for-profit insurer specializing in HDHP/HSA products.

2008

- Two PHSPs, Fidelis and CenterCare, complete their merger.
- PHSP Neighborhood Health Providers announces plans to acquire the Suffolk County Health Plan, that county's PHSP.

Sources: New York State Insurance Department, various reports; Securities and Exchange Commission filings; health plan websites; newspaper accounts; and *Consolidation of New York metro major commercial health insurance companies in our generation* (Gold Health Strategies, Inc. 2007).

consumers. Buyers of health care coverage have fewer choices in most markets than a decade ago, but even in New York's most concentrated market, the Rochester region, two health plans compete. In the Albany region, where CDPHP has a strong market share, two Blue Cross plans, GHI, and another strong regional HMO, MVP, compete. For businesses of sufficient size, self-funding offers an alternative to the traditional commercial market. One of Rochester's largest employers and health care providers, the University of Rochester, for example, opted out of the fully insured market and chose Aetna to administer its self-funded health plan.

Consolidation presents a different set of issues for health care providers, who believe they are forced to bargain with regional monopsonies. Concentrated markets in New York are to some degree responsible, many observers believe, for stagnant or declining reimbursement rates and "take-it-or-leave-it" contracts on unfavorable terms.

Some hospital systems, notably NewYork–Presbyterian Hospital, Continuum Health Partners, and North Shore-Long Island Jewish Health System, have strengthened their hands by forming networks of individual hospitals to bargain with health plans; some non-network hospitals, too, are located in less populated and rural regions in which they have a natural bargaining advantage in an unregulated hospital system. Some physicians have formed strong Independent Practice Associations, sometimes in concert with hospitals, and have relationships with health plans more like those of partners than antagonists. Clearly, solo and small group primary care practices bear the brunt of the increased market power health plans enjoy. In recent years, the legislature has considered legislation[23] to grant collective bargaining rights to health care providers practicing in concentrated markets.

Buyers: How New Yorkers Access Commercial Health Insurance Markets

Individuals

New Yorkers (and many out-of-state workers at New York firms) access commercial health insurance either as individuals or groups, or through rules for "in-between" arrangements or populations, such as associations and sole proprietors. Generally, New York laws guaranteeing access to all markets are among the strongest in the nation. The open enrollment provisions in New York's Community Rating/Open Enrollment (CR/OE) law give individuals, small groups, and their dependents the right to be "accepted at all times throughout the year for any hospital and/or medical coverage, including Medicare supplemental coverage, offered by the [health plan] to individuals and small groups in this state."[24] Under New York's guaranteed renewability provisions, coverage cannot be cancelled or non-renewed due to the claims experience of an individual or group.

Longstanding Insurance Law provisions set standards for eligibility under family contracts issued to individuals or employees and members of their families.[25] Family coverage is limited to the individual covered under the contract and his or her spouse, children, "or other persons chiefly dependent upon him [sic] for support and maintenance." Unmarried children "incapable of self-sustaining employment" due to mental illness or disability are entitled to remain covered under policies indefinitely; otherwise, children

23 A.4301/S.2886 of 2009.

24 NYIL Sections 3217(a) and 4317(a).

25 NYIL Sections 3216(a)(3) and (4), 4235(f), 4304(d), and 4305(c).

typically lose coverage at age 19 or, if attending college, at 23. Changes adopted in 2009 permit employer groups, at their option, to purchase riders that extend coverage for children, regardless of educational status, up to age 29.[26] Similarly, administrative rulings by the Insurance Department related to the "other persons chiefly dependent upon him for support and maintenance"[27] provisions permit health plans to offer coverage for domestic partners, but do not mandate that either health plans or employer groups offer it. New York health plans must also recognize same-sex marriages lawfully performed in other jurisdictions when applying family coverage standards, and must treat the parties to the marriage as "spouses" for the purposes of insurance coverage.[28] To discourage individuals and small businesses from waiting to buy coverage until a costly medical need arises, the CR/OE law and federal laws allow health plans to impose "pre-existing condition limitations" that may require out-of-pocket payments by enrollees, but limits how the provisions may be applied and for how long (see Appendix A).[29]

Continuation and Conversion. Like many states, New York has laws to help individuals find or maintain coverage when they lose coverage under a group plan. "Continuation" refers to the right of an employee or dependent to continue employer-based coverage when eligibility is lost due to a "qualifying event" such as termination of employment, changes in hours worked, divorce, separation, or the death of a policy-holder, or a child who "ages off" of coverage. The federal COBRA (Consolidated Omnibus Budget Reconciliation Act) law allows workers at firms with twenty or more workers and their dependents to extend their employer-based coverage under both fully insured or self-funded health plans for eighteen, twenty-nine, or thirty-six months, depending on the circumstances. New York's continuation law[30] extends similar COBRA benefits to workers at companies with fewer than twenty workers, and other groups not covered by the federal COBRA law, such as church-sponsored organizations, but applies only to fully insured plans. In 2009, legislation increased the COBRA limit from eighteen to thirty-six months.

The term "conversion rights" refers to New York statutory provisions that require health plans to allow enrollees who are losing eligibility in a fully insured employer-sponsored group plan to "convert" their group coverage to an individual plan.[31] Conversion rights are triggered by the same sort of events that lead to COBRA coverage (loss of employment, death, divorce, etc.), but the policies offer either more limited benefits or comprehensive coverage available to all individuals residing in New York. The option is available instead of COBRA, and when COBRA coverage expires.

Groups

Health plans cannot sell coverage to small or large groups unless those groups fall into one of fourteen categories defined in Insurance Law Section 4235(c). The clearly defined categories — various types of employer groups, union trusts, associations, or combinations of the three — are longstanding and are designed to protect the integrity and stability

26 NYIL Section 4303(d)(1).

27 NYIL Section 4305(c)(1).

28 New York State Insurance Department, Office of General Counsel. Opinion 08-11-05, issued November 8, 2005. Circular Letter 27 of 2008.

29 NYIL sections 3232 and 4318.

30 NYIL section 4305(e) and similar provisions in Section 3221.

31 NYIL section 4305(d) and similar provisions in Section 3221.

of the market, and the solvency of health plans. Generally, the intent is to ensure that participation is large enough to generate adequate premiums and spread risk, and to encourage coverage for organic groups that were formed to promote an economic enterprise or as a result of a collective bargaining agreement, rather than solely to obtain a better deal on health coverage. "Fly-by-night" association groups have been a major source of insurance fraud.[32]

Commercial insurers are also authorized to sell "blanket" accident and health insurance to special groups, such as students and workers at schools, or to groups or associations involved in a common enterprise or having a common interest or calling. In both group and blanket coverage, the employer group, school, or association is the policyholder, and persons covered under the policy receive certificates or "evidences of coverage" outlining their rights and benefits.

Small groups of between two and fifty employees are subject to the open enrollment provisions of the CR/OE law. The federal Health Insurance Portability and Accountability Act (HIPAA),[33] adopted four years after New York's CR/OE law, extends to both fully insured and self-funded large groups in New York some of the same protections, including guaranteed access and guaranteed renewability — although health plans can still vary large groups' premiums based on claims experience.

Association Groups

The ability of larger, experience-rated association groups to undermine community-rated markets is well documented.[34] Left to their own devices, large association groups can "cherry pick" lower-risk small groups and individuals by offering less expensive large-group rates. Because of CR/OE law restrictions on medical underwriting for small groups, New York has more stringent statutory and regulatory provisions than many other states regarding the eligibility of association groups for group coverage. Some association groups were grandfathered under the 1992 law, including groups made up of small businesses, dairy farmers, and auto dealers. Also, the Insurance Superintendent has the discretion to waive rules and allow certain organizations to form associations made up of individuals, to access the market as a group. Generally, however, any association group that includes a small-group member is subject to all the CR/OE provisions applying to small groups.[35]

Several brokers in the New York City market point to Professional Employer Organizations (PEOs) and employee-leasing firms as posing a similar threat to New York's community pools. New York State's Labor Law treats PEOs as "employers," and the State Insurance Department has ruled that PEOs are eligible to take out group policies that might cover many small employer groups within a larger pool.[36] This mechanism allows

32 See Kofman M. Summer 2005. *Association health plans: Loss of state oversight means regulatory vacuum and more fraud.* Georgetown University Health Policy Institute; Families USA. December 2005. *Association health plans: Bad medicine for small employers;* Kofman M. March 2004. *MEWAs: The threat of plan insolvency and other challenges.* New York: The Commonwealth Fund; U.S. General Accounting Office. March 1992. States need labor's help regulating multiple employer welfare arrangements; and U.S. General Accounting Office. March 3, 2004. Unauthorized or bogus entities have exploited employers and individuals seeking affordable coverage.

33 Public Law 104-191, 1996.

34 Hall MA. 2000. The geography of health insurance regulation. *Health Affairs* 19(2): 173-184; and Hall MA, EK Wicks, and JS Lawlor. 2001. HealthMarts, HIPCs, MEWAs, and AHPs: A guide for the perplexed. *Health Affairs* 20(1): 142-153. Both papers present excellent discussions on how experience-rated association groups can undermine community-rated pools and insurance regulation generally.

35 11 NYCRR 360, also known as Regulation 145.

36 New York State Insurance Department, Office of General Counsel. Opinion 06-10-03, issued October 23, 2006.

PEOs to offer small employer clients more favorable rates, along with other services such as payroll administration, enrollment, COBRA administration, cafeteria plans, and other services.

Sole Proprietors

Sole proprietors in New York straddle both the individual and Small Group markets, and are sometimes known as "groups of one." New York's original CR/OE law and regulations simply required health plans to categorize individual proprietors as either individuals or small groups, and left it to them to decide. In 2002, as many health plans moved to curtail arrangements giving sole proprietors access to Small Group rates, new legislation was adopted requiring health plans offering Small Group coverage through organizations such as local Chambers of Commerce to offer the same Small Group coverage to sole proprietors enrolled through such organizations.[37] The law, which was recently extended until 2011, currently allows health plans to charge a rate of up to 115 percent of the group rate for their sole-proprietor customers.

Chambers of Commerce, particularly upstate, are leading access points for sole proprietors seeking Small Group coverage. Chambers typically offer Small Group customers products that are the same as or very similar to those available in the commercial group market. The ability to offer health insurance coverage is a mainstay of chambers' marketing efforts to recruit and retain members, and an important source of revenue, since many of the organizations are themselves licensed agents and brokers that earn commissions on the products they sell. The Long Island Association Health Alliance and New York City-based HealthPass both offer programs for sole proprietors.

Underwriting

While state and federal laws restrict medical underwriting in New York's markets, underwriting — the rules health plans develop to evaluate groups' risk, and the terms under which insurance is sold — is an important factor in health insurance transactions. Underwriting guidelines are intended to protect health plans from adverse selection and maintain their profitability. The highly competitive nature of most markets, escalating medical costs, and the growing spread between comprehensive and lower-benefit plan designs are all factors in the priority health plans place on sound underwriting in the markets today.

Often administered by agents, health plan underwriting rules include many components:

- **"Minimum participation"** rules require a certain percentage of eligible employees within a firm to participate in health coverage. State laws require a 50 percent minimum participation rate,[38] and health plans have discretion to raise the limits further. Reflecting tight markets, some health plans have begun requiring employees who don't participate in their employer plan because of spousal coverage to submit copies of the spouse's insurance card. Regulations bar HMOs from using minimum participation rules for Small Group customers.

- **"Minimum contribution"** rules require employers to contribute a certain percentage of their group's premium, the theory being that without an employer contribution, only workers in need of coverage will purchase it.

- In **"multi-issue" arrangements,** employers provide health benefits through more than one health plan. Health plans and agents also use the term **"slice business"** to describe their end of these arrangements,

37 NYIL Sections 4317(b) and (f).

38 NYIL Section 4235(c)(1).

which often trigger new underwriting rules. The most common are restrictions on the combinations of products from which employer groups can choose. Much of the recent activity in this area results from the introduction of high cost-sharing designs into a market that still features comprehensive products with low cost-sharing features.

Health plans are loath to insure employees who choose comprehensive products while lower-risk workers in the same firm sign up for a competitor's high cost-sharing product. Most health plans have rules to prevent this "getting sliced" (as the practice is known), or at least make certain that they have the opportunity, along with their competitors, to offer both high- and low-cost-share plan designs to a group. Another growing trend is "full replacement," under which health plans offer employer groups, often at renewal, a take-it-or-leave-it proposition: either choose us for all your workers, under various plan designs, or go somewhere else for coverage. Underwriting guidelines also spell out details on which products can and cannot be offered in certain regions, whether reimbursement is based on the insured's residence or the business location, and which rating tiers are permitted.

Producers: Linking Buyers and Sellers

Except for segments of the Medicare market, individuals usually buy coverage directly from health plans. Groups, however, commonly use agents, brokers, or benefits consultants as intermediaries. With the passage of the federal Gramm-Leach-Bliley Financial Services Modernization Act in 1999, "producers" became the term of art for these foot soldiers in the health insurance markets.

Through the State Insurance Department's Licensing Bureau, New York issued individuals and corporations over 153,000 producer licenses for different "lines" or types of insurance. Over 100,000 licenses were issued in 2007 to life insurance agents with accident and health insurance authority, and 4,186 went to life insurance brokers with health insurance authority (see below for the distinction between the two). Another 37,000 health insurance licensees primarily represent property casualty insurers also authorized to sell health insurance. Many businesses entrust their health insurance decisions to agents who obtain the property and casualty coverages that are either mandatory or essential to running a business, such as workers' compensation, fire insurance, and liability coverage.

Many agents and brokers maintain licenses while not actively engaged in selling health insurance, and there are many producers with multiple licenses, or agents who are sub-licensees of licensed agencies, so the number of licenses is not an accurate reflection of the number of individuals who are actively out there selling. Still, there are a lot of people earning their living selling health insurance.

"I write 5,500 checks a month to brokers," says one senior executive at a downstate health plan. "I don't know more than 200 of them, but I send out the checks."

Article 21 of the New York Insurance Law provides that, in order to be licensed, agents and brokers must be over age 18, trustworthy (no felony convictions, for example), and competent. They must also prove that they've taken a minimum of forty hours of course work or have job-related experience, and have passed a test administered by an outside vendor for the type of insurance or "line of authority" to be conducted. Six broad lines of authority are defined, including accident and health insurance. The State Insurance Department collects a $40 annual fee for the licenses.

While most people in and out of the

industry use the terms "broker" and "agent" interchangeably, neither the Insurance Department nor the statute does. The key distinction is that agents represent insurance companies and brokers represent the insured. State regulations, however, permit both agents and brokers to obtain an "appointment" to represent a health plan. Most brokers and agents are usually paid through insurance company commissions, which are calculated as a percentage of premiums. Many agents represent multiple health plans offering health coverage in a given region. Alternatively, larger employers sometimes hire consultants or brokers to design and negotiate fully insured or self-funded benefit plans, for a fee or an hourly rate (known as fee-based compensation); often the payment reflects what the commission would have been had coverage been through a fully insured contract.

Commissions

Early iterations of New York Insurance Law Article 43 banned commission payments; HMOs weren't permitted to pay commissions until 1988. Instead, companies used salaried employees to market their products to businesses. The role of producers in the health insurance market still varies regionally. In the Rochester area, for example, where Excellus Blue Cross has a dominant market share, commission payments are a relatively new phenomenon for nonprofit plans, tied to efforts by for-profit Aetna Healthcare to enter the market. Commissions are a more recent development in the Western New York health insurance market as well.

In the downstate market, so-called "general agents" or "GAs" hold sway with most health plans. Operating under the same category of licensure as "regular" agents, general agents are instead akin to wholesalers or "super agents" to whom health plans pay an "override," an extra commission above the amount paid other agents. In return for the override, usually an additional 2 percent, general agents essentially take over the supervision of teams of agents selling the health plan's products. The GAs usually get an exclusive deal from the health plan so that all other producers must place business through them, rather than directly with the health plan. Those "selling agents" in turn may give over a portion of their own commissions to their GAs, in exchange for office and administrative support, access to MIS (management information system) tools, leads on business, and the ability to offer customers a large menu of services, such as Flexible Spending Account administration or employee enrollment.

Commissions paid to agents and brokers are based on schedules filed with the State Insurance Department as part of health plan rating manuals. The Department reviews the schedules for compliance with applicable laws[39] and regulations.[40] Base commissions, like the ones real estate agents earn from selling homes, are almost always figured as a percentage of premium. While commissions for HMO products are capped at 4 percent, no limits apply to products offered by Article 43s and Article 42s, except for overall minimum loss ratios or administrative expense caps for the companies, where applicable.

Experience-rated products, under which rates are calculated for each employer group, usually carry commissions in the 2.5 percent range — sometimes less for very large groups — but allow employer groups and brokers to negotiate different rates. Commissions for community-rated products are almost never less than 4 percent and are built into the community rate. Therefore, employer groups

39 NYIL Section 4234(h).

40 11 NYCRR 52.40, 52.42.

purchasing community-rated products incur this cost whether or not they use a broker to buy coverage. Some HMOs and other health plans pay higher commissions or make extra payments to brokers who conduct on-site sales pitches to employees or undertake administrative functions. Most companies pay the same percentage commission for new business or renewal, although health plans with strong market shares may pay lower renewal commissions.

Almost all health plans, however, pay bonuses in addition to base commissions. Health plans use the bonuses to help reach annual corporate goals, such as retaining business in the face of erosion from a competitor, improving results overall to hit a quarterly net income target, making a big bang in the market with a new product, or shifting enrollment out of one license or product to another.

Producers would never admit to doing anything other than what's best for their clients, and argue that competitive pressures prevent them from doing so; most can easily summon examples of losing accounts to lower-priced competitors. But bonus payments that tie compensation to making sure a business renews its policy, and to bringing in new business, seem to present interesting challenges.

Switching a client from an existing health plan to a new product, for example, could mean forgoing a renewal commission and a "persistency" bonus. Keeping a client in an existing HMO product could mean walking away from a significantly higher-percentage commission for a new exclusive provider organization (EPO) product that might be repeated on renewal.

The impact of commissions and bonuses paid to all types of producers — including those in auto, homeowner, life, and health insurance — was one focus of a series of public hearings conducted by the State Insurance Department and the New York State Attorney General's office in 2008. In January 2009, the State Insurance Department issued a draft regulation, "Producer Compensation Transparency," which provides "minimum disclosure requirements relating to the role of insurance producers and the actual or potential conflicts of interest created by compensation paid to insurance producers."[41] Commissions for larger employers are disclosed annually in Form 550 filings with federal agencies.

Health plan executives view producers as exercising a significant degree of control over the health insurance market. But could the world live without health insurance producers? Many market observers believe that small businesses, in particular, don't have the time or expertise to sort through complicated product designs. And as the intermediaries between health plans and businesses, producers have an unparalleled view of the health care system; the best ones have experience and special insights into the operations of health plans that they can put to use on behalf of clients. Simply eliminating commissions would transfer some portion of these expenses to salaried marketing staff at health plans. New technology is transforming the business, however. HealthConnect, a proprietary online quoting service, is a case in point (see sidebar, next page).

Brokers are conscious of the perception that as health insurance premiums have doubled, so have their incomes. Some brokers bristle at the notion, arguing that they have had to steer customers into higher cost-sharing models with lower benefits — and premiums. Others are sanguine about it: "Yep, business is good," said an Albany-based broker. Brokers also noted that the commissions pay for more than "gas and a telephone," such as the salaries of support and highly trained underwriting staff. All agree, however, that clients who are paying more for their

41 New York State Insurance Department. Draft of January 29, 2009. http://www.ins.state.ny.us/r_emergy/pdf/prodtrans090129.pdf.

HealthConnect

HealthConnect, the "online network for buyers and sellers of health insurance and employee benefits,"* has become an indispensable tool for health plans and producers in the downstate Small Group market, and an increasingly important part of the business of health insurance upstate as well. Described by one company official as "like Travelocity for health insurance," it might also be viewed as what a New York insurance "connector" might look like.

The classic entrepreneurial success story, HealthConnect began fifteen years ago, when a Long Island broker, frustrated at the time it took to get price quotes from health plans for his small business customers, retreated to a loft in his garage and began developing a database of health plan products and rates. Today, the company works with health plans, employer groups, employees, agents, and brokers in seventeen states, processing 10,000 quotes from agents and brokers daily.

HealthConnect's online quoting service is the core of its operations. Health plans pay a fee to list the products that they wish to market, and agents pay a subscription fee to use the system. General agents are allowed to privately brand their version of the service, and offer it for the use of their producers. What they buy is an elegant and user-friendly distillation of the products and prices in the Small Group market — "over 40,000 combinations in the New York metro area," a HealthConnect official notes.

In some respects, HealthConnect is possible because New York's regulatory framework made it vastly simpler to construct than it would be in most other states: only two variables — zip code and the combination of employee family sizes or "tiers" in a group — need be plugged in. Age, sex, medical history, industry, and other rating factors used in other states are irrelevant. Users simply select from a menu of health plans available in the zip code, then scroll across a single screen, selecting cost-sharing options and benefit riders from drop-down menus, until reaching the final column, where the monthly premium is calculated. Producers save the most promising quotes and, with another click, print a slick report for a sales presentation to employer groups that allows easy comparison of premiums and benefits. Alternatively, users can also select desired benefit designs and features, and have the system produce a report with all plans and products that fit the bill.

As HealthConnect's database expands, so do its products and services. The company recently loaded network providers' names into its system, so that when information about an employer group's use of providers is entered, producers can lead those groups to products that include the greatest number of providers used by the group's employees. HealthConnect also tracks producers' quotes, allowing health plans to use that activity to plan their own marketing strategies. For example, health plans can learn what the most popular drug benefit design was, in a given month, based on quotes sent to small-employer customers. More fundamentally, health plans can learn which competitor's new product is getting a lot of "hits," and adjust their benefit offerings accordingly. The company has also developed "HRConnect," an integrated human resources management system offered through agents, which allows employer groups and employees to research and transact business on a wide range of employee benefit functions.

* About us. http://www.healthconnectsystems.com/hcs/.

services are demanding more in return. Even small brokers have greatly expanded their offerings, helping set up tax-favored accounts that employers often offer as part of a benefit package, payroll administration, COBRA management, advocacy programs for employees fighting claims denials, and other services. State insurance regulators, meanwhile, are vigilant about brokers providing services for free, a violation of "anti-rebating" provisions in the state Insurance Law that are meant to prevent brokers from kicking back a portion of their commissions to customers. In March 2009, the Department issued detailed guidance to producers on which services were lawful and which were not.[42]

So how much *are* those commissions worth, anyhow? For a typical "case," the term brokers and plans use for business, a Manhattan firm with fifty employees and typical mix of family sizes would generate total monthly premium payments ranging from $37,000 (if all employees selected the lowest-cost product) to $92,000 (if all selected the highest-cost). Assuming a conservative 4 percent commission rate without any bonuses, the broker who arranged the initial sale or renewal would earn from $1,500 to $3,700 a month in commissions, or, if premiums were paid for the full year, $18,000 to $44,000 annually.

Because of varying reporting requirements and commission limitations among different types of licensees, coming to a marketwide figure for commission payments is difficult. But applying the same conservative 4 percent commission rate to total premiums for 2006 that were "commissionable" yields an estimate of between $800 million and $1 billion.

Commercial Marketplaces

Commercial enrollment in fully insured plans in New York (see Table 2, pages 26-27, for 2006 enrollment figures) is organized in three markets — Direct Pay, in which individuals purchase coverage directly from health plans; Small Group, which provides coverage for employer groups of two to fifty employees; and Large Group, for firms with fifty-one or more employees. Sole proprietors purchase coverage in both the individual and Small Group markets. Many individuals also access the group market through associations.

While it may not have resulted in the kind of price declines consumers would like to see, health plans cite fierce competition in group markets across the state. "It's the most competitive I've seen it in fifteen years," said an official at a national plan active in the Northeast. "If you get a benefit wrong or are off on price a point or two, you can lose 20,000 members in a couple of months," said another national health plan executive.

Upstate, a stagnant economy — even before the financial crisis that has gripped the nation — adds to competitive pressures. "You go to a conference in Dallas or Atlanta, they're growing 10 and 15 percent just on new jobs," said an upstate health plan official. "Around here, if we want to add a member, we have to take them from somebody else." That challenge is compounded when health plans seek to reduce costs by organizing more restrictive provider networks. "Everybody is in everybody's network," said one upstate health plan official. Said another, "We looked into putting together a network that didn't include the Catholic hospital system, but people didn't like it. Even if they had never been treated there, and didn't know anyone who had been treated there, they wanted that Catholic hospital in the network."

In some upstate markets, where two or three plans compete for members, the competition resembles nothing so much as World War I-style trench warfare: the bugler sounds (open enrollment period), the health plan launches an attack (rolls out a new

42 New York State Insurance Department. March 3, 2009. Circular Letter No. 9. Permissible services of insurance agents and brokers; rebating and inducements.

product line) and advances a hundred yards (takes some business from its competitor), then retreats the following year after suffering heavy losses. "The market's just too tight," said an upstate health plan official.

New York's restrictions on medical underwriting magnify the importance of benefit design in the dynamics of market competition. Health plans are wary of adverse selection, and increased cost-sharing designs have been a way to both restrain premium increases for employer groups and avoid higher-risk populations. Brokers and agents speak knowingly of health plans with "tainted pools," products for which the price is rising due to the claims experience of insured groups. And health plan actuaries speak with grudging admiration of competitors' successful efforts to "cleanse pools" — altering the benefit structure to drive high-cost enrollees to different health plans by, for example, scaling back a comprehensive drug benefit. Plans are also on the lookout for competitors who "drop the floor" — pricing a product below estimates of its actual cost, in order to boost market share or retain business.

Direct Pay

If you think of New York's risk pooling structure as a game of musical chairs, people in the Direct Pay market are the ones left standing around when the music stops. While in other market segments risk is spread through large pools, New York's Direct Pay market is in trouble because risk is spread through increasingly smaller pools of purchasers, with costly medical expenses. Increasingly, the market is referred to as one for "the sick and the wealthy."[43] Mark Scherzer, legislative counsel for the consumer group New Yorkers for Accessible Health Coverage, has called the market a "high-risk pool with an inadequate subsidy."

Despite state stop-loss funding and Regulation 146 risk-adjustment funds (see Appendix F) that reduce rates by an estimated 14.6 percent, premiums for individual coverage are approaching or exceeding $1,000 per month for single adult HMO coverage at most plans, and rates for family coverage at the two plans with the largest enrollment fall in the $3,000-to-$4,300-per-month range.

Individuals seeking comprehensive coverage are limited to the two standardized HMO/POS products authorized in 1995 (see Appendix C, "Why Are New York's Individual Market Benefits So Comprehensive?").[44] Enrollment in the two standardized products and in similar managed care products grandfathered by state law has declined from over 100,000 in 2000 to an estimated 46,500 by the end of 2007. In 2006, enrollment in Direct Pay HMO/POS products totaled an estimated 57,000, with another 38,000 members enrolled in "other" products, including indemnity policies grandfathered after the enactment of the CR/OE law, and limited benefit designs such as "basic hospital" and "basic medical" policies. Empire reported 7,400 enrollees in their hospital-only product, for example.[45] (State regulators consider Medicare Supplement coverage to be part of the Direct Pay market, as well; these products are addressed in the Medicare portion of this report.) Total direct pay premiums were an estimated $435 million in 2006 for these products.

Direct Pay enrollment is concentrated downstate; 78 percent of enrollment is in the New York City region, mainly through Empire and Oxford, with over 17,000 and 22,000 members, respectively, in 2006. Both plans earned healthy profits on that business, results rarely matched when the State Insurance Department's prior approval

43 Wagar M [Empire BlueCross BlueShield president]. October 30, 2007. Promoting private coverage solutions to the issue of the uninsured. [Presentation]

44 Except where otherwise noted, data for the Direct Pay and Small Group markets are from Gorman 2008. [Note 1]

45 Enrollment as of November 2007, cited in personal correspondence, December 2007.

Table 2. **New York Enrollment in Health Insurance Plans, 2006**

Article 44 HMOs	Direct Pay	Commercial Group	Healthy NY	Medicare	Medicaid	Child Health Plus	Family Health Plus	TOTAL
Aetna Health	8,667	160,199	10,404	12,955				192,225
AmeriChoice				1,138	94,265	1,333	14,983	111,719
Atlantis Health Plan	42	10 ,480	1,698					12,220
CDPHP	560	181,421	5,888	11,663	35,965	18,425	6,773	260,695
Cigna Healthcare	3,808	15,825	4,723					24,356
Community Blue/ HealthNow New York	313	136,775	5,772	29,037	30,121	11,132	7,818	220,968
ConnectiCare of New York	2	34						36
ElderPlan				16,888				16,888
Empire HealthChoice HMO	17,138	381,719	34,301	64,195		64, 550		561,903
Excellus Health Plan HMO	1,521	344,747	12,354	56,873	64,263	45,285	17,772	542,815
GHI HMO	186	28,684	3,548		13,124	2,969	6,573	55,084
HIP	9,646	547,692	6,175	125,445	189,331	13,101	51,058	942,448
Health Net of New York	1,345	155,151	527	6,388				163,411
Independent Health Association	1,794	197,231	6,559	38,651	25,150			269,385
Managed Health Inc.	3	14	909	72,516	2,381			75,823
MDNY Healthcare	75	23,563	1,699					25,337
MVP Health Care	127	217,345	11,818		3,347	1,545	1,365	235,547
Oxford Health Plans	22,729	402,190	12,978	69,803				507,700
Preferred Care	382	111,990	1,205	61,502	17,578			192,657
UnitedHealthcare of New York	7			10,300	62,081	11,535	25,225	109,148
WellCare of New York				13,849	61,080	12,612	29,654	117,195
Subtotal 2006	68,345	2,915,060	120,558	591,203	598,686	182,487	161,221	4,637,560
2006 Line of Business %	1.5%	63.1%	2.6%	12.7%	12.8%	3.9%	3.5%	100.0%

Article 43 Nonprofit Insurers	Provider Services	Preferred Provider	Indemnity Only	Other	TOTAL
CDPHP Universal Benefits	31,341	9,045			40,386
Excellus Health Plan		403,990	752,468	43,633	1,200,091
Group Health Inc.	1,550,230				1,550,230
Health Insurance Plan of Greater New York		9,898		3,265	13,163
HealthNow New York		98,828	215,384		314,212
Independent Health Benefits	983	15,795	843		17,621
Preferred Assurance		828			828
Subtotal 2006	1,582,554	538,384	968,695	46,898	3,136,531
2006 Line of Business %	50.5%	17.2%	30.9%	1.5%	100.0%

Table 2. **New York Enrollment in Health Insurance Plans, 2006** (cont.)

Article 42 Accident and Health Insurers	Individual	Group	Health Savings	Medicare Supp	Medicare Part D	Out of Network	Other	TOTAL
Aetna Health Insurance of America						48,069		48,069
Empire HealthChoice Assurance*	11,008	2,324,057	1,207	65,842		45,435	7,197	2,454,746
Health Net Insurance of New York		67,169			46,846			114,015
HIP Insurance Company of New York						63,525		63,525
Horizon Healthcare Insurance Company of New York		19,711					29,236	48,947
Humana Insurance Company of New York					139,058			139,058
MVP Health Insurance		9,788				27,276		37,064
Oxford Health Insurance	6,439	917,103						923,542
PerfectHealth Insurance Co.		2,629						2,629
United HealthCare Insurance Company of New York	608	1,249,701		229,891	215,941			1,696,141
Subtotal 2006	18,055	4,590,158	1,207	295,733	401,845	184,305	36,433	5,527,736
2006 Line of Business %	0.3%	83.0%	0.0%	5.4%	7.3%	3.3%	0.7%	100.0%

Prepaid Health Services Plans	Medicaid	Child Health Plus	Family Health Plus	TOTAL
Affinity Health Plan	134,408	28,577	43,244	206,229
Amerigroup	79,047	17,907	29,106	126,060
Centercare	55,471	4,117	10,010	69,598
Community Choice Health Plan	10,750	3,666	1,943	16,359
Community Premier Plus	64,724	3,021	8,550	76,295
HealthFirst PHSP	268,765	29,562	69,429	367,756
HealthPlus	186,918	24,951	44,286	256,155
Hudson Health Plan	34,677	19,354	7,472	61,503
MetroPlus Health Plan	186,902	18,432	37,451	242,785
Neighborhood Health	75,412	8,058	16,616	100,086
NewYork-Presbyterian	45,990	3,492	11,398	60,880
NYS Catholic Health Plan (Fidelis Care)	184,973	37,313	42,911	265,197
Suffolk County	10,786	3,817	72	14,675
Total Care (Syracuse Community Health Center)	18,450	3,284	3,302	25,036
Univera Community Health	17,441	6,201	9,425	33,067
2006 Subtotal	1,357,273	205,551	325,790	1,888,614

* Article 43 companies reporting Point of Service enrollees that are understood to be HMO enrollees for whom a related Article 43 company underwrites the out-of-network benefit: CDPHP/Universal Benefits – 2,739; Community Blue/HealthNow – 113,178; Excellus – 150,527; Health Insurance Plan of New York – 70,628; Independent Health Association/Benefits – 35,861; Preferred Assurance/Preferred Care – 12,658. These are not included in this table to avoid double-counting. In addition, the following Life, Accident & Health insurers report selling out-of-network benefits, which may result in double-counting of HMO and Accident and Health enrollees: Aetna Health, Empire HealthChoice Assurance, HIP Insurance Company of New York, and MVP Health Insurance Co.

Source: Author's analysis of health plan annual statements, New York State supplements, and Medicaid Managed Care reports submitted to Department of Health. Dental- and vision-only enrollment not included.

authority was in place and most health plans generated negative loss ratios on their individual business.

Upstate, Direct Pay enrollment ranges from 2 percent in the Syracuse and Utica/Watertown regions to 6 percent in Buffalo. Community-rated Direct Pay pools in upstate regions are very small. Excellus and HealthNow — the largest health plans upstate, with combined premium income of almost $7 billion in 2006 — reported Direct Pay HMO/POS enrollment of just 1,521 and 313 individuals, respectively.

Other Individual Enrollment

While the standardized HMO/POS direct pay market receives most of the attention (or inattention, depending on your perspective) in terms of enrollment, there are significant pockets of individual enrollment outside this market.

Over 100,000 individuals and sole proprietors earning less than 250 percent of the federal poverty level (FPL) are covered through the Healthy NY program (see below), a public/private hybrid offered to income-eligible individuals, sole proprietors, and small groups at a community rate that blends the experience of all three groups.

Sole proprietor enrollment data are sketchy, as this market segment is diffused through the Direct Pay, Healthy NY, and Small Group markets, as well as through associations, Chambers of Commerce, and purchasing alliances such as the Long Island Association Health Alliance, HealthPass, and the Freelancers Union.

Both the Long Island Association and HealthPass offer sole-proprietor products in New York City and the suburban counties, through health plans such as HIP, GHI, Atlantis, and Oxford. HealthPass, the non-profit trust established by the New York Business Group on Health and the City of New York, recently began offering five sole-proprietor products from Oxford, ranging from $314 monthly for individual coverage in an HSA plan to $401 monthly for an in-network-only product.[46] The Long Island Association Health Alliance Enterprise program offers sole proprietors a HIP HMO product for $419 monthly.[47]

Freelancers Union. Over 17,000 individuals who live or work in New York are covered under an unusual arrangement through the Freelancers Union group health insurance program.[48]

Although the organization does not meet the traditional standards for group insurance eligibility, it functions as an association group through the grant of "discretionary group status" by the State Insurance Department.[49] In recent years, ten other organizations have received the designation, but most are inactive.[50]

The Freelancers Union — known earlier as the Portable Benefits Network, and affiliated with Working Today — was originally established to provide coverage for freelance technology workers in Manhattan's "Silicon Alley."[51] Today, eligibility for its group health plan is based on two main criteria: the type

46 HealthPass website, rates effective 4th quarter, 2008.

47 Long Island Association Health Alliance website, for rates effective April 1, 2009. http://www.liahealthalliance.com/ent_rates.asp.

48 Horowitz S. April 29, 2008. Bridging the gap: Affordable health care for New York's uninsured. Presentation to Manhattan Institute Conference Series.

49 New York State Insurance Department response to United Hospital Fund FOIL request. September 16, 2008. Authority for discretionary group status at 4235(c)(1)(M) of the Insurance Law.

50 Other discretionary groups include the working poor, unemployed, and laid-off workers enrolled in the Rochester-area Excellus ValueMed Plus product; a group trust established in 2000 to permit low-income, uninsured, part-time and seasonal workers in Central New York purchase an outpatient health insurance product known as Safety Blue; and a post-9/11 group established by Oxford Health Plans and HIP for victims of the World Trade Center attacks.

51 Health insurance for freelancers: A new group focuses on overlooked workers. *New York Times*, October 2, 2002.

of work or "industry" in which the member is engaged, and whether the member meets the organization's definition of an independent worker.

In 2008, the Freelancers Union switched most enrollees from HIP, the carrier that provided coverage from the program's inception in 2004, to Empire. In 2009, it opened a licensed Article 42 insurer, Freelancers Insurance Company, offering coverage directly to members through BlueCross BlueShield provider networks. Because enrollment growth exceeds the required threshold, premiums are based only on members' claims experience, and are not pooled with either the individual or Small Group markets. Benefits are provided through PPOs, with rates ranging from $460 per month per individual for more comprehensive coverage to $150 a month for a plan with a $10,000 in-network deductible and a $15,000 out-of-network deductible.[52]

In other states, the Freelancers Union offers enrollment in its "individual plan" through Golden Rule Insurance Company, a UnitedHealth Group subsidiary known for its aggressive medical underwriting.[53]

Healthy NY. The Healthy NY program provides coverage for about 145,000 individuals, sole proprietors, and small-business workers and their dependents. Established in 2000, along with Family Health Plus, by the landmark HCRA 2000 legislation, Healthy NY straddles the public and private markets, including features from both. Individuals, sole proprietors, and small groups pay a single community rate, varying only by region and family size.

More than two-thirds of those enrolled in 2007 were individuals (53 percent) or sole proprietors (16 percent).[54] For people with lower incomes, Healthy NY functions as an alternative individual market; within Empire, for example, Healthy NY enrollment now approaches all health plans' enrollment in standardized individual HMO/POS products. Empire, Excellus, and Oxford together enroll more than half of all enrollees; Empire alone enrolls over one-third of the total.[55]

Healthy NY imposes income eligibility standards, but no asset test, for individuals and sole proprietors; income limits for small-group members are less rigorous. Individuals and sole proprietors are eligible for enrollment if they reside in households earning 250 percent FPL or less ($55,125 for a family of four). Small-group eligibility is based on just the salary of the employee, not on household income. Small groups are eligible for Healthy NY if at least one-third of enrollees earn less than $38,000 (a figure adjusted upward annually), as long as one employee "takes up" coverage. Eligibility is further limited, for both individuals and employer groups, to those who have not had comprehensive insurance coverage for the previous twelve months, although a number of exceptions apply.

All HMOs in the state are required to offer the Healthy NY benefit package, which is set in statute. While commercial HMOs are mandated to offer the product, they may, however, impose pre-existing-condition limitations, not the case in public programs such as Child Health Plus, Family Health Plus, or Medicaid Managed Care.

A key component of the Healthy NY design is the reduction of premiums by eliminating benefits required for other individual and group policies issued in New York, and by limiting benefits not required but often a feature of small group policies. Healthy NY provides no coverage for mental health or substance abuse treatment, dental or vision care, chiropractic care, hospice care, ambulance services, or durable medical equipment.

52 Freelancers Union website. http://www.freelancersunion.org/insurance/new-york/index.html.

53 After caesarean, some see higher insurance cost. *New York Times*, June 1, 2008.

54 EP&P Consulting, Inc. January 2008. 2007 annual report on Healthy NY.

55 Ibid.

Enrollees have the option of a generic-only drug benefit, capped at $3,000 annually, or of no drug coverage, the choice of 20 percent of enrollees. Although there is no general deductible, deductibles or co-pays do apply for inpatient care ($500), surgery ($200), outpatient surgery ($75), ER visits ($75), and prescription drugs ($100), and there is a $20 co-pay for doctor visits and tests.

Under the Healthy NY statute, the Insurance Superintendent enjoys broad discretion to vary benefits. In 2006, an HDHP/HSA policy was added; although fewer than 700 Healthy NY members purchased the product in 2007, enrollment has reportedly been growing of late. In 2007, coverage was added for home health care, physical therapy, and prostate cancer screening.

A second key component of the program is a stop-loss subsidy, designed to be invisible to enrollees, which reduces premiums through payments to health plans, rather than to enrollees themselves. Currently, health plans are eligible to receive 90 percent reimbursement for enrollee claims that fall within a stop-loss corridor of $5,000 to $75,000 annually.

New York State appropriated $123.4 million in calendar year 2007 for stop-loss subsidies for individual and small-group claims; about $92.5 million of that amount was paid out to carriers. The payments reduce Healthy NY premiums by nearly 30 percent. Premium payments from individuals and employer groups and state stop-loss payments together totaled $355 million in 2007. The state's FY 2009-2010 budget appropriates $161 million for the program, with funding coming from assessments on all domestic insurers, instead of HCRA.

Going forward, however, Healthy NY faces several key challenges:

Benefits. With the 2006 "Timothy's Law" mandate for mental health coverage in Small Group policies, Healthy NY is now the lone program in New York's public or commercial insurance markets that provides no mental health or substance abuse benefits. With increased evidence of the social costs of mental illness, the ongoing availability of special subsidy funds for the recent small-group mandate, and recent action on federal mental health parity legislation, it is unlikely that the exclusion of these two benefits will be sustainable for much longer. Increased attention by employer groups and commentators to "value-driven" benefits packages and chronic disease management may also impel an update of Healthy NY's current benefits, particularly concerning prescription drug limitations.

Price differentiation. Healthy NY is still markedly more affordable than the standardized HMO/POS individual products, but the gap between Healthy NY and Small Group coverage is shrinking, due in part to increased cost-sharing designs. In Kings County, for example, Healthy NY products with a drug benefit range from $248 to $351 monthly; commercial products with similar benefits are available for as low as $291 monthly, without public subsidies.[56] Exemptions granted to certain association plans — the Freelancers Union, for example — have eliminated the gap between Healthy NY rates and these associations' individual rates.

Subsidy. The State Insurance Department is proud of the administrative ease and simplicity of the stop-loss mechanism and the positive attention it has received, but some questions remain about the stop-loss/subsidy structure. Although small-group enrollment has slowly increased to about 30 percent of total enrollment, the program has never leveraged the employer group participation that was expected; early appropriations for the program anticipated small-group enrollment four times

56 Health Connect Plan Wizard, rates as of June 2009.

Brooklyn HealthWorks Brings Healthy NY to Borough's Small Businesses

Launched by the Brooklyn Chamber of Commerce in 2004, the Brooklyn HealthWorks program now provides modified Healthy NY coverage through GHI to over 300 small businesses and 1,500 workers and dependents in the borough. The Chamber's effort illustrates both the strengths and weaknesses of the Healthy NY program. The biggest shortcoming of the Healthy NY program — leveraging more employer participation — has been Brooklyn HealthWorks's success. But the group has accomplished that by supplementing the existing stop-loss subsidy mechanism, altering the Healthy NY benefit package, and waiving the statutory requirement that businesses contribute 50 percent of the premium.

After years of experimentation and lots of shoe leather, Brooklyn HealthWorks and partner GHI hit their stride when grant funds were used to offer a Healthy NY product without the big-ticket deductibles that turned off low-wage workers, a deeper subsidy than Healthy NY stop-loss alone, and eliminating the need for gatekeepers and referrals — further reducing premiums. When foundation support ran out, state lawmakers — led by the Brooklyn delegation — threw the program a lifeline in 2007 by authorizing it to tap into Healthy NY funds earmarked for the Insurance Department's promotional activities. In March 2009, the Paterson Administration announced funding for a similar initiative in the Syracuse area, known as HealthCore, and sponsored by a local Chamber and UnitedHealthcare.*

Following its earlier design, Brooklyn HealthWorks offers two basic GHI Healthy NY packages, one for additional cost, but without exposure to the nearly $800 in deductibles for inpatient care and surgery. Premiums for the cheaper plan are $235 for employees monthly, or $249 for the deductible-free package. Without the additional premium payments to GHI on top of state stop-loss, the packages would cost $290 to $308 per month; without state stop-loss support, premiums would fall in the $377 to $399 range.**

* Governor Paterson announces program to offer affordable health insurance in Central New York. March 12, 2009. [Press release]

** Brooklyn HealthWorks. January 21, 2009. [PowerPoint presentation]

higher than individual enrollment. Regulators worry that it is difficult to determine if insureds are getting the full value of the subsidy in a file-and-use rate-making system. And open-ended income limitations make it difficult to determine who, exactly, is getting the benefit of the small-group subsidy.

The salary-based income standard yields eligibility for small-group coverage at about 390 percent FPL, without counting household income. Since only one-third of individuals need to meet the income standard for the entire group to be eligible, and only one individual need enroll in coverage for the entire group to receive the subsidy, a group of ten might have ten eligible individuals or one, and even those eligibles might have incomes exceeding traditional household income standards applied to public programs.

On the individual side, questions loom about whether the program will ever be able to deliver a subsidy sufficient to enroll the lower-income workers who form the core of New York's uninsured population, or whether that population is better served with an expansion of Family Health Plus income limits, as contingently approved in the recently enacted budget for FY 2009-2010, or 2007 changes to

public programs such as the Family Health Plus Employer Buy-In and Premium Assistance Programs. Policymakers will have to carefully assess how Healthy NY fits in to an overall state strategy.

Looking broadly at the individual market and "other enrollment" through sole proprietor programs, Healthy NY, and association plans, state policymakers face another thorny issue. Viewed one way, these programs are creative options that are providing invaluable coverage to tens of thousands of New Yorkers. Viewed another, they are viable only because nearly a decade of neglect of individual market problems and the lack of a coherent strategy to manage risk has created a marketable premium differential. On the benefit side, state policymakers, in a bid to bolster community pools, mandated comprehensive benefits and resisted efforts to weaken them; subsequent decisions allowed state programs (Healthy NY) and certain associations the ability to offer lesser benefit packages and "select against" the Direct Pay market. Healthy NY promotional materials trumpet "premiums as much as $878 less than average individual rates," as if the state had nothing to do with them.

Small Group

New York's Small Group market comprised an estimated 1.7 million enrollees in 2007 — a decline of 100,000 from the previous year — paying about $6.5 billion in premiums. As in the Direct Pay market, Small Group enrollment is concentrated in the New York City region (58 percent), with upstate pockets ranging from 9 percent in the Rochester and Buffalo regions to 4 percent in the Albany region (Table 3 shows combined Small Group/Direct Pay premium distributions). In the New York City region, Oxford/UnitedHealthcare and Empire were the leading Small Group insurers; upstate, Excellus, MVP, HealthNow, Independent Health, and CDPHP each had strong enrollment.

Despite the growth of newer product designs such as EPOs, the Small Group market remains an HMO/POS market in the eyes of most observers. An estimated 60 to 70 percent of Small Group members are enrolled in HMO/POS products, with 15 to 20 percent of members in PPO designs, and 10 to 15 percent in other products. While health plan officials and producers report that enrollment is shifting to the EPO/PPO designs, the availability of HMO products, while it may be short-lived, has allowed small groups to access comprehensive benefit packages with low cost-sharing.

HMOs reported $180.3 million in net income for Small Group business in 2006 and Article 43s reported over $31 million in combined income from their HMO line of

Table 3. **Annual Premiums by Region, New York Direct Pay and Small Group Markets, 2007**

Albany	Buffalo	Mid-Hudson	NYC	Rochester	Syracuse	Utica/ Watertown
$373,390,364	$448,714,502	$381,242,199	$4,986,481,795	$336,988,760	$326,680,289	$178,096,899
5.31%	6.38%	5.42%	70.92%	4.79%	4.65%	2.53%

Source: New York State Insurance Department.

business and non-HMO products (see Table 19, page 84).

HealthPass. Some small groups access the market through HealthPass, New York's home-grown "connector." Started by the City of New York and the New York Business Group on Health, HealthPass began operations in 1999, and in 2007 organized health coverage for over 2,400 employer groups in the city and the suburban counties, with 18,300 covered lives. Enrollment surged to over 30,000 in 2009. A nonprofit trust, HealthPass uses a third-party administrator to enroll small-business workers in some twenty-five products offered by three insurers: HIP/GHI (part of the EmblemHealth line-up), HealthNet, and, for sole proprietors only, Oxford/UnitedHealthcare. About a third of enrollment is based in Manhattan.

Prices for HealthPass coverage range from a $157 monthly individual rate for a GHI HDHP/HSA to $739 for a GHI PPO. In-network-only and out-of-network plan designs are offered, with and without specialty referrals, with a wide range of cost-sharing options, including general, hospital, and prescription drug deductibles, and in-network and out-of-network coinsurance. Most plan offerings are available in the Small Group market.

The strengths of HealthPass identified in an earlier review of its operations[57] remain its strengths today: solid management, a strong relationship with the broker community, significant simplification of the enrollment process for employer groups, and perfect positioning to deliver "defined contribution" arrangements, in which employer groups make a fixed monthly payment and employees can choose from a variety of plans and products through their own contribution. Over time, HealthPass has added other services, such as life and disability insurance, COBRA, and Section 125 pre-tax account administration and claims advocacy. Some of the same challenges continue, too. Despite strong enrollment growth, HealthPass relies on fees from participating health plans to support its operations, greatly eases the enrollment process for businesses but pays brokers commissions, and has experienced limited success enticing additional health plans to offer coverage through the program.

Large Group

Health plans reported enrollment in fully insured comprehensive group coverage of 10.6 million in 2006. Several challenges exist, however, in quantifying enrollment, particularly when compared to Census data. First, since enrollment is based on where the employer group is located, not on enrollee residence, enrollment figures for Small- and Large-Group fully insured plans and self-funded plans capture residents of other states. The Large Group market (companies with over fifty employees) presents some additional challenges, since it includes enrollment under the New York State and City public employee programs, with services provided by separate vendors (see section on public employees, below). Empire and United, for example, would each report over 1 million enrollees under the New York State Empire Plan. Finally, enrollment figures include Medicare-eligible retirees covered by employer group plans that supplement Medicare coverage. The arrangements are known as "carve-outs" because the premium is reduced to reflect coverage under Medicare and the employer's plan.

Adjusting for these factors, we estimate an enrollment of 6.4 million in the fully insured Large Group market, split almost equally between for-profit plans such as Empire and Oxford/UnitedHealthcare, with

57 Rosenberg SN. 2003. *New York's HealthPass purchasing alliance: Making coverage easier for small businesses.* New York: The Commonwealth Fund. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221452.

their downstate market dominance, and among (still) nonprofit HIP/GHI downstate and upstate nonprofits such as Excellus, HealthNow, CDPHP, MVP/Preferred Care, and Independent Health.

HMOs reported $256.3 million in net income from Large Group business, and Article 43s reported $415.3 million from combined HMO and non-HMO Large Group operations (see Table 19, page 84). Article 42s do not report net income separately for the Large and Small Group markets, and instead reported total net income for both markets of $525.7 million. Some 2 million Large Group members were enrolled in HMO-based products, and the remainder were in PPO, indemnity, and EPO plan designs.

One cause for concern in this market is the decline in community-rated Large Group coverage, particularly upstate. Blue Cross plans such as HealthNow and Excellus still voluntarily provide community-rated Large Group coverage to some customers, and HMOs are required to community-rate Large Group HMO products — but not to offer them. In response to anti-selection pressures, many health plans are instead promoting HMO/POS or indemnity-based EPO and PPO plans that are not required to be community rated. As a result, the Large Group, community-rated market is increasingly populated by groups with higher-than-average claims experience, insufficient resources to self-fund, or both. Brokers report that health care institutions such as hospitals and nursing homes are their biggest customers for these contracts.

Public Employees. Health coverage for public employees constitutes a significant share of the New York commercial market. The three largest public employee benefit programs in New York — the New York State Health Insurance Program (NYSHIP), New York City Health Benefits Program (NYCHBP), and Federal Employee Health Benefits Program (FEHBP) — provide coverage for over one-third of New Yorkers enrolled in the Large Group, fully insured commercial market.[58] Policymakers eyeing public employee programs as a delivery system for the uninsured should beware, however. The programs are unique and complex. Long-tenured state officials administering NYSHIP (pronounced "nigh-ship") say it's aptly named: "Like an ocean liner, it doesn't turn very easily," said one official.

NYSHIP. NYSHIP was created by the Legislature in 1957; its Empire Plan, the product of a collective bargaining agreement between the state and public employee unions, was rolled out in 1986, replacing the Statewide Plan and the GHI option. This public employee health plan featured old-fashioned indemnity coverage through basic hospital and basic medical benefits offered by nonprofit plans, and a major medical policy from MetLife wrapped around it, but only lower-income workers received a "paid in full benefit" — health care coverage without significant cost sharing. Empire Plan premiums jumped for public employers by 4 percent that year, and by 11 percent the following year. A major brouhaha developed in 1988 when Empire Plan administrators announced the need for a 60 percent increase.[59] Local government officials howled, insurance company executives blamed co-pay-free access to services, state officials cited a drop in local government participation, and union officials claimed insurer skullduggery.[60] State legislation allowing for program losses to be repaid over a three-year period, more modest premium increases, and utilization controls stabilized the program.

58 Aggregate enrollment for NYSHIP, NYCHBP, and FEHBP of 2,665,000, based on reports of 2007 enrollment by the three plans of 1,250,000, 1,100,000, and 315,000, respectively.

59 Inquiry planned into premium rise. *New York Times*, December 27, 1987.

60 Troubles of Empire Health Plan were built in by the insurers. *New York Times*, February 6, 1988.

Today, NYSHIP claims status as one of the "largest public employer health insurers in the nation, outside of the federal government," insuring one out of every twenty New Yorkers. As of August 2008, 1,278,690 individuals were covered under the program[61] — 1,023,000 active public employees and dependents, and 255,000 retirees and dependents enrolled through both the Empire Plan and local HMOs.

"A Plan as Great as the Empire State." A complex and multi-faceted organization with many constituencies, NYSHIP is administered principally by the Department of Civil Service (DCS), with the active involvement of two other agencies, the Governor's Office of Employee Relations and the Division of Budget. Nine state public employee unions organized into fourteen bargaining units are active participants in decisions on benefit design and other issues, through Joint Committees on Health Benefits. NYSHIP arranges coverage for state workers, but acts more like an insurer for local governments, competing with insurers and third-party administrators to win the business. While coverage is offered for state workers in HMOs, NYSHIP regards HMOs as competitors to the Empire Plan, and seeks to maintain and increase enrollment in the latter.

Unlike commercial and nonprofit insurers, NYSHIP pools the risk of both active and retired employees and dependents, including Medicare-eligibles. Unlike health plans, it charges one statewide premium, rather than carving up service areas into small, cost-sensitive rating territories. NYSHIP must control costs without increasing cost-sharing or reducing benefits, unless ratified in the collective bargaining process. Although premiums are based on enrollee experience, in many ways it's the ultimate community-rated pool in New York State, with small and large public employers, and retirees, pooled together and paying one statewide rate.

With over 200,000 retirees covered, NYSHIP is a huge provider of secondary coverage to Medicare enrollees, facing the same challenges that large private employers faced with the adoption of the Part D drug benefit. Collective bargaining provisions in place for active employees make NYSHIP look, at times, like a Taft-Hartley trust. Even though it operates as a fully insured plan, program administrators strive to leverage some of the advantages of self-insurance funding to hold down rates. In its day-to-day operations, NYSHIP closely resembles a self-funded plan in most respects.

Enrollment. NYSHIP enrollment is open to elected officials, employees, and retirees of the executive, legislative, and judicial branches, and New York State agencies; "participating employers" such as the Thruway Authority and the Dormitory Authority; and workers in local government units, or "participating agencies." There are more than 100 participating employers and over 800 participating agencies, including 18 cities (e.g., Yonkers), 11 counties, 85 fire districts, 38 housing authorities, over 100 libraries, 150 school districts, 135 towns, and over 200 villages, ranging from Airmont (pop. 9,000) to Woodsburgh (pop. 871).

New York State employees and retirees number nearly 325,000, not counting dependents; nearly 199,000 active workers and dependents from participating agencies are also in the Empire Plan. Only the Empire Plan is open to employees of participating agencies; state workers may enroll in the Empire Plan or in one of the dozen HMOs participating in the NYSHIP program across the state. Membership is heavily concentrated in the Empire Plan, however, with 89 percent (1,082,768 employees and dependents) enrolled there, compared to 12 percent (145,922) enrollment in HMOs.[62]

61 New York State Department of Civil Service, NYBEAS Enrollment System. August 2008.

62 New York State Department of Civil Service, NYBEAS Enrollment System. October 2007.

Table 4. **NYSHIP Enrollment Concentrated in Certain Counties**

Empire Plan Enrollment, by County		
Suffolk	195,046	18.1%
Nassau	157, 871	14.7%
Westchester	50,204	4.7%
Orange	38,491	3.6%
Queens	32,760	3.0%
Albany	32,407	3.0%
Dutchess	25,759	2.4%
Erie	21,565	2.0%
Broome	14,208	1.3%
TOTAL		**52.8%**

HMO Enrollment, by County		
Erie	30,335	20.8%
Albany	20,967	14.4%
Monroe	11,078	7.6%
Schenectady	10,849	7.4%
Rensselaer	8,523	5.9%
Saratoga	6,909	4.7%
TOTAL		**60.8%**

Source: New York State Department of Civil Service.

Department of Civil Service officials indicate that HMOs have lost membership to the Empire Plan for the past several years, at a rate of 2 percent annually.

Enrollment in both the Empire Plan and in HMOs is heavily concentrated in a handful of counties (Table 4). For the Empire Plan, Long Island participating employees account for one-third of enrollment. Similarly, two counties account for over a third of NYSHIP HMO enrollment, with concentrations in a handful of regional HMOs such as CDPHP and MVP in the Capital district, Independent Health and HealthNow in the Buffalo area, and MVP/Preferred Care and BlueChoice (Excellus) in the Rochester area. All Blue Cross plans in New York share in the Empire Plan business; even though Empire BlueCross BlueShield holds the hospital contract, Blue Cross plans service each other's members when they live outside of defined regional territories.

Benefits. NYSHIP members enjoy comprehensive benefits that, as expected, compare favorably to those for non-unionized, non-public employer groups. Full prescription drug coverage is provided, along with durable medical equipment, orthotic and prosthetic device, hearing aid, and skilled nursing facility benefits. Dental and vision services, provided outside the Empire Plan health insurance structure, are offered to state employees at no additional cost. Cost-sharing is more limited than in most commercial plans.

Except for modest co-payments, members are fully reimbursed for care by in-network providers, and reimbursed at 80 percent of the cost for out-of-network care, using a usual-and-customary fee schedule developed exclusively for the Empire Plan. Since 2004, members have the added option of reducing out-of-pocket costs for out-of-network care by using a provider participating in a second network, Multi-Plan. The provider network is large and nationwide — 11,000 hospitals, skilled nursing facilities, and hospice care centers, over 170,000 medical, mental health, and other participating providers, and a mail order/retail drug program with a choice of more than 59,000 participating pharmacies.

Benefits are determined through the collective bargaining process overseen by the Governor's Office of Employee Relations. At the table with the Office are fourteen separate collective bargaining units represented by

nine public employee unions, including the Civil Service Employees Association (CSEA), Public Employees Federation, New York State Correctional Officers and Police Benevolent Association, Council 82 and District Council 37, and the Police Benevolent Association of New York State Troopers. The Governor's Office of Employee Relations and the unions use Joint Committees on Health Benefits established for each bargaining unit to hash out benefit and administration issues, and monitor participating HMO performance. But since the plan is fully insured, negotiations on benefits occur within the confines of mandated benefit provisions and consumer protections contained in state law. The most active areas of discussion generally relate to benefits and design features not prescribed by state law — prescription drugs, durable medical equipment, and orthotics, for example — and cost-sharing provisions.

Empire Plan benefits are typically shaped in cycles consistent with the collective bargaining on multi-year contracts with state workers. The most recent contract with the public employee unions, negotiated in 2007, extends through 2011 and includes provisions to:

- Increase co-payments for ER visits, outpatient surgery, participating provider office visits, ambulatory surgery centers, and non-preferred name-brand drugs, and phase out special benefits for out-of-network hospital care;
- Expand prior-authorization requirements for MRIs to all imaging services;
- Add coverage for diabetes education and other diabetes-related needs, and for the shingles vaccine for workers over age 55; and
- Improve travel and lodging benefits available in conjunction with the use of Centers of Excellence for cancer, infertility, and transplant treatment.

The agreement also sets attainment goals, to be reached during the contract period, for a wide range of issues: extending disease management programs (currently in place for cardiovascular risk reduction, asthma, and diabetes) to chronic kidney disease, eating disorders, and ADHD; considering the addition of a Center for Excellence for bariatric surgery; exploring a co-payment waiver program for office visits and drugs related to chronic illnesses; making potential changes in the pharmacy benefit; and reviewing the role of nurse practitioners in the Empire Plan provider network.[63]

While the core of Empire Plan benefits is similar for all the bargaining units, each one can and does negotiate minor variations in benefits for members. CSEA, for example, which represents lower-salaried state workers, seek to reduce out-of-pocket costs, while law enforcement units have fought for Lasik surgery.

Cost Containment and Quality. NYSHIP's primary cost-containment tool is an old-fashioned one: its insurance vendors use the program's size to leverage large volume-based discounts with providers. While a process exists for non-hospital providers to receive increases above the standard rate, it is used sparingly, usually in conjunction with a particularly strong regional provider or for services such as pediatric oncology or pediatrics, where keeping the provider in the network makes the Empire Plan more competitive with local HMOs. NYSHIP also offers disease management programs comparable to those in place at commercial insurers, and maintains Centers of Excellence for high-cost treatments for infertility, cancer, and transplants. The program is not an active participant in regional or national quality improvement, health information technology, or pay-for-performance initiatives, but is exploring these areas. In 2009, NYSHIP

63 Collective bargaining agreement 2007-2011, Administrative Services Unit, CSEA. http://www.csealocal1000.org.

contracted with an outside vendor to conduct a "dependent eligibility project" to make sure covered dependents are entitled to coverage.

Premiums. New York State pays 90 percent of the cost of Empire Plan premiums for individuals and 75 percent for dependents (no matter how many are covered by the policy), so the effective state contribution for family coverage is 82 to 83 percent. Employee contributions do not vary by region. In 2008, state employees covered under the Empire Plan paid biweekly contributions of $22.19 for individual coverage and $95.10 for family coverage. NYSHIP applies the same contribution rate to members who enroll in HMOs, but caps its dollar contribution at the level of the Empire Plan premium. Biweekly employee contribution rates vary greatly by region for HMOs, ranging from a low of $15.09 for individual coverage with Preferred Care in the Rochester area to $80 for the Empire BlueCross HMO in the Mid-Hudson region.

Participating agencies must agree to contribute at least 50 percent of the total employee premium, and 35 percent of the dependent premium (though most pay the entire premium, NYSHIP officials say), and pay a monthly administration fee of $2.39 per enrollee. Two options are available, the Excelsior Plan and the Empire Plan, with a slightly higher benefit level. Premiums for the Empire Plan in 2008 were $592 for individual coverage and $1,258 for family coverage, about 12 percent more than for the Excelsior Plan.[64] Current monthly premium charges for active state employees, which reflect the application of monies returned to the state (as explained below), are $462.74 for individuals and $1056.23 for families.

For the 2007 policy year, the Department of Civil Service estimated total Empire Plan premiums of $5.226 billion, based on carriers' estimates of claims experience.[65] Within that total, Empire BlueCross BlueShield earned $1.609 billion in premium for the hospital benefit (31 percent), UnitedHealthcare $2.042 billion for outpatient services (39 percent), GHI $94.2 million for mental health/substance abuse services (18 percent), and Empire BlueCross BlueShield $1.480 billion for drug benefits (28 percent). The health plans anticipated paying out $4.448 billion in claims expenses in the aggregate and retaining $349 million to cover their expenses and profits. Under the Plan's prospective rating scheme, premiums in excess of anticipated claims experience and agreed-on health plan administrative costs, known as "dividends," are returned to the state and can be applied to offset future years' premium. Under the agreement with the health plans, the state also accrues some of the benefit of interest income, on funds set aside to pay claims, that a self-insured plan would enjoy.

For FY 2008-09, New York State budgeted $1.652 billion for health insurance costs for active employees and $1.039 billion for retirees.[66] State spending on the program grew 10.3 percent in FY 2006-07, 5.4 percent in 2007-08, and 5.5 percent in 2008-09, and is projected to increase by 9.5 percent in both 2009-10 and 2010-11. A breakdown of gross rate premiums over the years,[67] reflecting biweekly premiums for one NYSHIP collective bargaining unit, unadjusted to reflect premium reductions due to dividend payments from health plan providers, is illuminating, as shown in Table 5.

Despite its size, NYSHIP was not immune to the double-digit rate increases that buffeted employer groups in the early 2000s; of late, it has benefited from moderating premiums.

64 New York State Department of Civil Service. http://www.cs.state.ny.us/ebd/ebdonlinecenter/pamarket/rates.cfm.

65 New York State Department of Civil Service. April 8, 2008. PA 08-03, Empire Plan quarterly experience report.

66 New York State Division of the Budget. May 1, 2008. New York State 2008-09 enacted budget financial plan.

67 New York State Department of Civil Service. Management and confidential enrollees. New York group rates 1999-2008 biweekly rates. [2006 and 2007 rates exclude Medicare Part B surcharge.]

Unlike most employer groups, however, it maintains its two-tier rating system (a fixture in many union-related benefit plans), rather than the three- or four-tier systems used for most employer-sponsored plans.

Since claims expenses lag well behind the end of policy years, Empire Plan accounting occurs on a rolling basis. The process of setting premiums for the coming year begins in April, when participating agencies receive their first notice of projected rates for the following year, but starts in earnest when Department of Civil Service administrators send "call letters" to participating insurers, which work under multi-year contracts, asking for their "premium demand" — each insurer's estimate of the premiums it will charge Empire Plan enrollees in the coming year.

Armed with the previous six months' actual claims experience, health plans "name their number," based on their projections of claims, medical trends, taxes, administrative costs, and the always contentious "risk charge" that is tacked onto the rate. Over the next few months, state officials, union leaders, and health plan officials haggle over the rates until there's agreement on the numbers.

Executive budget documents issued in 2008 credit Department of Civil Service staff with knocking $58.2 million off initial health plan proposals. In 2009, Governor Paterson and DCS officials announced that Empire Plan premiums would rise only 1.2 percent — saving local governments millions of dollars — due to savings achieved in negotiations with health plans.[68] But at the same time, Department officials are wary of the limitations of their purchasing power in the market: the health plans "ultimately set the premium," as one official said. The pool of insurers capable of organizing and paying claims for statewide networks is limited. Although the drug benefit has changed hands in recent years, the same lineup of insurers providing hospital and medical benefits now (since UnitedHealthcare administers the outpatient benefit through the MetLife unit it purchased) did so thirty years ago. And

68 Press release from Governor David Paterson. December 5, 2008. Governor Paterson announces historically low insurance rate increases will benefit local government.

Table 5. **Empire Plan Biweekly Premium Increases, 1999-2008**

	Individuals	% Change	Family	% Change
1999	$106.61	5.4%	$241.35	4.8%
2000	$118.24	10.9%	$263.46	9.2%
2001	$130.89	10.7%	$290.74	10.4%
2002	$141.68	8.2%	$318.57	10.6%
2003	$161.08	13.7%	$364.15	14.3%
2004	$181.31	12.6%	$406.25	11.6%
2005	$196.04	8.1%	$438.85	8.0%
2006	$213.21	8.8%	$481.05	9.6%
2007	$227.24	6.6%	$517.30	7.5%
2008	$237.34	4.4%	$547.01	5.7%

Source: New York State Department of Civil Service.

hardball negotiation tactics are risky when 1.2 million people in a multifaceted program depend on you for health insurance. Last-minute changes are not an option.

Federal Employee Health Benefits Program. The Federal Employee Health Benefits Program (FEHBP) provides health insurance coverage to almost 8 million federal employees and retirees. In 2007, it covered approximately 315,000 New Yorkers: 203,000 current employees and their dependents, and 112,000 retirees and their dependents.[69] Federal employees choose from an array of plans, some offered nationwide and others only in certain states or localities. Most plans are open to all federal employees but some are only available for certain groups of workers, such as postal employees.

The Blue Cross and Blue Shield Association (BCBSA), the national federation of Blue Cross Blue Shield insurers, is the largest national FEHBP plan; services to enrollees are provided through local Blue Cross Blue Shield plans. The BCBSA and its three Blue Cross franchisees in New York cover 40 percent of federal workers enrolled in New York, the largest share.[70] GHI and Aetna each cover approximately 15 percent of state enrollees, and HIP another 8 percent. The remaining enrollees are covered by the other six plans that participate in New York and another four national plans.

FEHBP enrollment in New York is concentrated in the greater New York City area. Almost 40 percent of FEHBP enrollees reside in New York city, and residents of Nassau and Suffolk account for another 15 percent each.[71]

There is no prescribed benefit package for FEHBP, and benefits vary from plan to plan. Most plans offer some combination of high-option, standard, and basic packages. Standard plans typically offer coverage with out-of-network providers, whereas basic plans are restricted to in-network providers. High-option plans may offer enhanced benefits or lower cost-sharing.

Blue Cross Blue Shield offers a comprehensive benefit package covering prescription drugs, vision care, dental care, orthotics and prosthetics, physical/occupational/speech therapy, durable medical equipment, and limited hearing care. Since Blue Cross Blue Shield accounts for almost 60 percent of national enrollment, its benefit package is typically used as a benchmark for FEHBP coverage.[72]

The government contributes the lesser of 72 percent of the average FEHBP premium or 75 percent of the plan premium.[73] Premiums vary by plan and product. In 2008, Blue Cross Blue Shield monthly employee contributions ranged from $85 to $134 for an individual, and $199 to $314 for a family; GHI employee contributions ranged from $97 to $206 for an individual, and $225 to $588 for a family; and Aetna employee contributions ranged from $67 to $157 for an individual, and $147 to $444 for a family.[74]

FEHBP premiums have grown more slowly than the private market's. From 1969 through 2003, FEHBP premiums increased at an average rate of 10.6 percent annually. By contrast, private health insurance premiums rose an average of 11 percent per year.[75] Recent cost savings are attributed to offsets in increases from plan reserves. Projected

69 U.S. Office of Personnel Management. Health Benefit Data File plan totals, 2007.

70 Ibid.

71 Ibid.

72 Senator Wyden's Healthy Americans Act uses Blue Cross Blue Shield's FEHBP product as a benchmark.

73 Davis K, BS Cooper, and R Capasso. November 2003. *The Federal Employee Health Benefits Program: A model for workers, not Medicare*. New York: The Commonwealth Fund.

74 U.S. Office of Personnel Management. Non-postal premium rates for the Federal Employees Health Benefits Program. http://www.opm.gov.

75 Davis, Cooper, and Capasso 2003. [Note 72]

withdrawals from reserves offset 2 percent of premiums in 2006 and 5 percent in 2007,[76] but the Office of Personnel Management announced average increases of 7 percent for 2009.[77]

The government's share in FEBHP costs for New York State enrollees exceeded $1.3 billion in 2007. Federal spending on New York State non-postal employees was about $540 million, while spending on postal workers in the state equaled about $500 million. About $360 million was spent on retirees.[78]

New York City Health Benefits Program

New York City's Health Benefits Program provides health benefits for 1.1 million workers, dependents, and retirees covered under about 555,000 contracts, just shy of NYSHIP's total. Of the total contracts, 342,000 covered active employees, and the remainder retirees.[79] Like the Governor's Office of Employee Relations, New York City's Office of Labor Relations negotiates benefits and employee contributions with the Municipal Labor Committee, comprising unions such as District Council 37, the United Federation of Teachers, and the Patrolmen's Benevolent Association.

Over 70 percent of enrollment is concentrated in a joint product offered by GHI and Empire. Similar to the Empire Plan, the GHI-Comprehensive Benefits Program/Empire package includes a PPO design for outpatient services, Empire hospital coverage, and GHI coverage for mental health services and prescription drugs. Membership in HIP's HMO product accounts for another 20 percent of enrollment. New York City employees could pick from nine additional plans in 2008, including Cigna, Aetna, and HealthNet, and retirees were offered another five plans.[80]

While many features of the New York City employee benefits program are similar to those of the state plan, others are unique. By local law,[81] for example, the city's contribution to health benefits is limited to the "HIP rate" — the community rate that HIP uses for its commercial customers. Based on the monthly HIP premium of $312 for individuals and $764 for families, the city was expected to pay over $2.2 billion in FY 2009 for the health benefits of active and retired workers.

Another unique feature relates to employee contributions. "Basic plans" available through GHI/Empire and HIP are offered at no cost, while basic plans from other insurers require a payroll deduction, which can reach as high as $1,200 a month for coverage offered by Aetna with an out-of-network benefit. Optional riders offered to workers supplement basic plan coverage, providing prescription drug coverage and sometimes other benefits. Some city employees have access to these optional benefits through their union welfare funds, but others must purchase the riders. The cost of the optional riders ranged from $20 to $35 per week for individuals.[82] A separately negotiated program known as PICA provides additional coverage for injectable drugs and chemotherapy.

Although the City of New York solicited

76 Government Accountability Office. December 2006. Federal Employees Health Benefits Program: Premium growth has recently slowed, and varies among participating plans.

77 U.S. Office of Personnel Management. September 25, 2008. [News release]

78 U.S. Office of Personnel Management. 2007. 2007 enrollment and premium data.

79 New York City Office of Labor Relations. March 28, 2007. Exhibit 9: Health plan enrollment by contract type as of 12/31/06. Request for proposals for hospital, medical, mental health/chemical dependency, and prescription drug benefit coverage for City of New York employees and retirees, and their dependents, Office of Labor Relations, New York City.

80 An additional plan, Med Team, is excluded from this count since it is only open to DC 37 members.

81 New York City Administrative Code, Section Sec. 12-126.

82 New York City Office of Labor Relations. Basic plan and optional rider costs for employees. http://home2.nyc.gov/html/olr/html/health/rate_chart.shtml.

bids from health plans to administer the program in 2007, it has not announced any winners.

Other Public Employee Groups. Many other options exist for public employers to obtain coverage for their workers. Westchester County and Schenectady County, for example, organize their own fully or partially self-funded arrangements for workers. Ten consortiums of local public school districts have formed municipal cooperative health benefit plans (MCHBPs), entities licensed by the State Insurance Department under Article 47 of the Insurance Law. Although usually self-funded in full or in part, the MCHBPs are actively supervised by state regulators, and benefit plans conform to state health benefit mandates.

Benefits and Products: What Buyers Buy and Sellers Sell

Health plans sell products in New York's commercial markets that are a mix of benefits required by statute or regulation, and judgments health plans make about additional features and packaging that will attract buyers.

Benefits

Question: What are three health insurance benefits *not* mandated for all non-HMO policies in New York State?

Answer: Hospital care, physician care, and prescription drugs.[83]

Surprised? The answer highlights the complex interplay of New York Insurance Law and Public Health Law statutory provisions, and regulations issued by the Insurance Department and the Department of Health that dictate the benefits that must be included in health insurance coverage in the state. Benefit requirements vary according to the type of health plan offering the benefits, and the market segment to which products are offered. Inclusion of certain kinds of benefits can trigger requirements for additional benefits, or minimum dollar amounts that must be included in coverage.

In the individual market, all HMOs must offer New York residents comprehensive benefits set out in detail in statute.[84] HMOs must also participate in a second "forced market," the Healthy NY program, for which benefits are also prescribed. Although these are the only comprehensive products that may be offered to individuals, health plans are permitted to offer limited benefit plans to individuals. Rules for these limited benefit plans, and all coverage offered to groups, are contained in Insurance Law provisions governing health insurance contracts issued by Article 43 nonprofit insurers, HMOs, and Article 42 commercial insurers, and a pioneering Insurance Department regulation that dates back to the era of Governor Nelson Rockefeller.

The regulation, known as Reg. 62[85] (described in detail in Appendix D), was an early effort to standardize health benefits and improve disclosure in order to ease comparison shopping, and protect consumers from deceptive sales pitches or benefit packages that did not provide "real economic value." Reflecting the types of benefit packages prevalent in the early 1970s, Reg. 62 establishes minimum benefit levels for insurance covering hospital care (basic hospital or "hospital only"), physician services (basic medical), and a combination of the two kinds of coverage (major medical). The regulation also permits the sale of limited-benefit accident and health insurance

83 New York State Insurance Department, Office of General Counsel. July 19, 2004. Opinion on limited benefit policies.

84 NYIL Sections 4321 and 4322 for Direct Pay policies, and NYIL Section 4326 for Healthy NY policies.

85 11 NYCRR 52.

products by Article 42 insurers, as long as they do not cover hospital care and do meet State Insurance Department standards.[86]

While the evolution of benefit design has made Reg. 62 less important, its minimum standards still apply in certain instances. Individuals who purchase the hospital-only policies that are still available today from some Article 43 insurers,[87] for example, are entitled to benefits for maternity care and anesthesiology during their hospital stays. And while it is rare for comprehensive policies offered in New York to have low annual or lifetime benefit caps, "Smart Start" coverage, offered by HIP to Long Island employers, carries a $100,000 annual benefit cap — the minimum required for major medical coverage under Reg. 62.

As the influence of Reg. 62 has waned, the importance — and length — of the statutes governing health insurance contracts has waxed, as new benefit requirements have been added through legislation over the years. For nonprofit insurers and HMOs, statutory benefit requirements are laid out in Insurance Law section 4303. Mandated benefits begin with subsection "(a)" (preadmission testing in hospitals before surgery), run through "(z)" (prostate cancer screening), and continue on, currently reaching "ee" (a ban on using an autism diagnosis to exclude otherwise covered benefits) on the second run through the alphabet. New York Insurance Law section 3221 dictates benefits for groups enrolled through Article 42 companies, and mirrors the benefit requirements in section 4303. As an overlay to the Article 43 requirements, HMOs are also required to offer "comprehensive health service plans."[88] Formal and informal Department of Health guidelines limit cost-sharing for traditional HMO products.

Mandates' Scope and Costs. In New York, mandated benefits are categorized as either provider mandates (covering care from a chiropractor or podiatrist, for example) or service mandates (reimbursing for mammography screening). Whether these mandates must be included in policies can depend on a variety of factors. Echoing the earlier tripartite structure of benefit design included in Reg. 62, New York's diabetic supplies mandate applies only to policies covering doctor visits, and home care is required for all policies covering hospital care. More recent mandates apply to policies providing "major-medical or similar type comprehensive coverage." Prescription drug coverage is not mandated in New York; mandates such as contraceptive coverage apply, if the employer group chooses to provide a drug benefit.

Some mandates (such as hospice care) are not mandates at all; health plans must only "make available" the benefit, and employers decide whether to purchase it. Multistate employers and employee benefit plans subject to collective bargaining are exempt from some mandates. Mandates related to maternity coverage, mental health coverage, and breast cancer treatment are required by federal law for some groups.

All these variables make determining the number of mandates actually in effect in New York something of a fool's errand — but that hasn't stopped people from trying. A coalition of state Blue Cross plans puts the number of individual mandates at forty-three.[89] A checklist for commercial products, provided

86 New York State Insurance Department, Office of General Counsel. July 19, 2004. Opinion on limited benefit policies.

87 Both GHI and Empire BCBS offer hospital-only plans. The premium for Empire's TraditionPLUS Hospital Program, as of April 1, 2007, was $136 monthly for an individual in New York City, and $122 monthly in the Albany area.

88 NYPHL Section 4401.

89 New York State Conference of Blue Cross and Blue Shield Plans. 2009. Your health insurance, your money: How taxes and state laws make health insurance cost more every year and what you can do about it. http://www.nysblues.org/policy/index.htm.

to health plans by state regulators, lists thirty-three benefit mandates of various kinds, with twenty-three "mandate mandates," and the remainder "make-availables," or benefits conditioned on drug coverage.[90] An insurance industry lobbying group, the Council for Affordable Health Care,[91] puts New York in a third-place tie with Virginia at fifty-five, trailing Maryland (sixty-three) and Minnesota (sixty-four).

Whatever the number, business groups and health plans have consistently pointed to benefit mandates as the cause of high premiums and uninsurance. The rise in premiums is indisputable: national surveys show a nearly 50 percent jump from 2003 to 2007,[92] and a 2006 New York State survey by a leading business group[93] reported six straight years of double-digit premium increases, averaging 12.7 percent in 2005 and 12.3 percent in 2006. But from 2003 through 2006, New York State mandated only one new benefit, related to coverage of ambulance services. In 2007, the mental health parity mandate known as Timothy's Law carried with it a $100 million subsidy for small groups, to offset any premium increase related to the new benefit.

Estimates of the premium impact of new mandated benefits suffer from the same flaws as estimates on existing ones — the difference between the "actuarial value" of benefits, and the "marginal cost." An actuarial value estimate of the premium impact of a new prescription drug mandate in New York, for example, would develop a premium impact figure based on prescription drug spending. A marginal cost analysis would recognize that such benefits are widely included in benefit packages despite the absence of a mandate, and would calculate the increased costs that might result.

Frequently cited in New York debates on mandated benefits is a 2003 analysis sponsored by a business group[94] that uses the actuarial method — a measure of the cost of each benefit. It references over thirty mandated benefits, ascribing a 14.7 percent increase in direct costs due to the mandates currently on the books, and 12.2 percent increase in net costs.

Studies measuring marginal costs of mandated benefits — the actual premium increase a business might face as a result of mandated benefits — have been widely embraced as more accurate measures. Studies undertaken in New Jersey and Minnesota[95] suggest cost increases from mandates of perhaps three to eight percent. And a study commissioned by the Texas Insurance Department[96] found that, while mandated benefits "represent 6.3 percent to 7.6 percent of current group insurance costs in Texas... we would not conclude that these mandates are greatly influencing the affordability and availability of health insurance to individuals in Texas."

Another study[97] found that the sheer

90 New York State Insurance Department checklist for group hospital/medical products issued by Article 42 insurers, as of September 2007. http://www.ins.state.ny.us/acrobat/ah_compmedgrp.pdf.

91 Council for Affordable Health Insurance. 2008. Health insurance mandates in the states 2008. Alexandria, VA: The Council for Affordable Health Insurance.

92 Kaiser Family Foundation/Health Research Educational Trust. 2007. Survey of employer sponsored health benefits.

93 New York State Business Council. August 30, 2006. Survey: Health insurance costs for New York's employers, employees continue to increase – although the pace is moderating.

94 NovaRest Consulting. May 2003. New York State mandated health insurance benefits.

95 Rutgers Center for State Health Policy. January 2007. *Assessing the impact of mandated health insurance benefits on cost and coverage;* and Minnesota Department of Health, Health Economics Program. July 2001. *Mandated health insurance benefits and health care costs*.

96 Albee SK, E Blount, MG Hansen, TD Lee, M Litow, and M Sturm. September 28, 2000. *Cost impact study of mandated benefits in Texas: Report #2.* Austin: Texas Department of Insurance.

97 Henderson JW et al. September 12, 2005. State-level health insurance mandates and premium costs. *Journal of Economic Literature*.

number of mandates is not relevant to the cost of coverage. Instead, both cost decreases and increases are possible depending on the type of mandate analyzed, and the type of health plan to which it applied. Introducing data showing that offer rates of small employers and take-up rates by employees have not declined between 1996 and 2003, despite the enactment of many new benefit mandates, a health policy analyst aptly summarized the debate: "The continued focus on exemption from benefit mandates is curious, given the amount of scholarship devoted to this issue… and given the consistency of the analytic literature's conclusion that benefit mandates do not add much to the cost of major medical/comprehensive health insurance policies. Perhaps the methodological arguments and studies about the precise effects of mandates on premiums are too technical to be believed since the academic research seems to contradict apparent common sense."[98]

Certainly mandated benefits do matter; even trifling ones add an "administrative load" to coverage via the cost of reworking information systems, contracts, riders, member handbooks, and the like. While the number of mandated benefits actually adopted in New York has slowed in recent years, the number of bills to add mandated benefits topped 120 in the New York legislature's 2008 session, as individual legislators respond to constituents with costly medical needs that are not covered by their insurance, or provider groups look for a more direct role in the health insurance system. That should provide ample fodder for the Health Insurance Quality and Cost Containment Review Commission. Authorized in 2007 but yet to begin its work, the Commission is charged with evaluating the impact on cost and quality of new mandated benefits, at the request of the Governor or the chairs of the Senate or Assembly Insurance Committees. With a slightly broader mandate, the Commission — or a similar entity — could alter the shopworn dynamic of the current discussion on mandates, and provide a forum for a long-overdue discussion on benefit design that provides value and promotes health and cost containment.

Products

Consumer Reports' *Automobile Buying Guide* may seem an unlikely place to start to get a handle on the plethora of health insurance products available on the market today, but an actuary at a leading New York City health plan suggests car manufacturing might be just the place: "We sell chassis," he says. "You can build them up with all sorts of variations and riders, but we all sell chassis — PPO, EPO, HMO, POS, and indemnity."

Product designs start at the State Insurance Department's Health Bureau, where policy forms are reviewed. These include all the documents related to the product an individual or employer group buys, including the actual policies or contracts that are the bases for the coverage, certificates that group members receive, riders providing additional benefits, lists of exclusions, and all forms signed by applicants during the enrollment process. In 2007, the Health Bureau reviewed over 1,400 policy form submissions from health plans, approving over 700 of them.

Once policy forms are approved, they end up "on the wall" on the nineteenth floor of the Insurance Department's Albany office, a large room with floor-to-ceiling shelves where the forms are kept, organized by company and by year. The policy forms are for the most part public documents once they are approved and can be obtained through a Freedom of Information Law (FOIL) request.

Platforms and Suites. Once the Insurance Department's work is completed, health plans'

98 Nichols LM. April 6, 2006. Small employer health insurance: First, do no harm, then, do the right thing. Statement before the U.S. Senate Committee on Finance.

sales and marketing staffs take over, often rolling out new "suites" (the in-vogue term for new product lines) just in time for open enrollment periods at large employer groups. Larger employer groups typically allow employees to switch plans in the fall, with a January 1 effective date, while smaller employer group renewals are spread through the year.

Virtually all health plans offer a complete range of products, including old-fashioned indemnity policies, but benefit packages are typically offered across multiple "platforms" or structures, such as HMO/POS, or EPO/PPO (see Appendix A). While health plans do not, for the most part, report enrollment by specific categories of product design in a systematic way across all licensees, health plans and brokers agree that EPOs are the fastest-growing segment of the market. The EPO design can be offered with or without the gatekeeper function that has proved unpopular with customers. It allows health plans to leverage discounts with providers through the creation of a network, and permits cost-sharing designs not permitted for HMO products.

In terms of the product options offered to employer groups, brokers and agents report that a "core/buy-up" design remains the most prevalent among larger employers. This offers employees a basic core product, with the ability to buy up to a richer design with a higher contribution toward the premium. Some brokers report that employers are adding a third option to the mix, a high-deductible health plan/health savings account, with or without an employer contribution to the account.

Gated or Ungated, Open or Closed. Whatever the platform, all products boil down to four key variables: 1) gated or ungated — whether prior authorization through a "gatekeeper" is required to access services; 2) open or closed — whether enrollees are limited to reimbursement for in-network coverage only; 3) cost-sharing — high or low; and 4) the "drug card" — the type of prescription drug benefit provided. The use of these product design elements has substantially blurred — or obliterated — the traditional distinctions between types of health plans.

Cost-Sharing. In the face of the steady and inexorable increase in health care cost inflation, health plans struggle to maintain profit and reserves while delivering products to the market at prices most nearly resembling the previous year's premium. Most plans seek to maintain product portfolios that include most categories of products (HMO, POS, PPO, EPO, and, for most plans, indemnity coverage) at staggered price points, so that employer groups can renew policies at premium rates comparable to their current plans. In trying to hit these targets, health plans look to a number of options, including "squeezing" providers for lower rates, eliminating benefits, and, increasingly, imposing cost-sharing benefit designs.

Cost-sharing provisions have become more common and more complex (see "Cost-Sharing," Appendix A). Health plans typically require enrollees to pay fees when they see health care providers, co-payments that can range from $15 for a doctor visit to $500 for an inpatient hospital admission. But in addition to co-payments, cost-sharing can, depending on the plan design, include five separately calculated components: in-network deductibles, out-of-network deductibles, in-network coinsurance, out-of-network coinsurance, and a separate deductible for prescription drugs.

Adding another layer of complexity, coinsurance payments are based on three values. First, the plan uses its own schedule of what it considers a typical payment for a service to be — the "usual, customary, and reasonable" charge, or UCR. Then it sets

the percentage of the schedule it will use, often ranging from 60 to 100 percent of UCR. Next, payments to consumers are further defined (and usually reduced) by the "percentage of the percentage" that the plan will pay. For example, a plan might use 80 percent of UCR as base, and then reimburse 60 percent of that amount to the consumer, up to the out-of-pocket maximum exposure for the insured. Sometimes plans use different percentages for in-network and out-of-network coinsurance. Complicating matters further, coinsurance maximums under family coverage sometimes apply to the family's overall costs and sometimes are calculated based on each family member's costs. Most policies with cost-sharing include "out-of-pocket maximums." But these limits usually do not cover co-payments, and may or may not count deductible expenses toward the limit.

Increased cost-sharing poses challenges for buyers, regulators, policymakers, and even the sellers themselves. It has obvious appeal to health plans for a number of reasons. It helps offset inexorable health care inflation and improves premium quotes to employer groups by transferring expenses from premiums to employee out-of-pocket costs. It can also enhance the risk profile of groups, since healthier people will tend to embrace high cost-sharing designs. At the same time, however, the designs reduce revenues by reducing premiums, both creating pressure on underwriting income and reducing investment income. And in competitive markets, when one health plan "pushes the envelope" with higher cost-sharing designs, the others tend to follow suit, or risk losing business to their lower-priced competitor.

For consumers, the trend means a less valuable insurance benefit, the need to budget for unexpected costs, and, in more and more cases, crushing medical debt.[99]

For regulators and policymakers in states like New York, with a strong tradition of market regulation, cost-sharing has increasingly concentrated risk in comprehensive benefit designs; created tension about how to appropriately manage different licensees; raised questions on the appropriate degree of intervention in markets in which consumers, employer groups, and health care providers are all struggling with increasingly complex insurance contracts and reimbursement schemes; and produced an uncomfortable and growing gap between public program and private market benefits.

The Attorney General Weighs In. One recent regulatory development could influence the use of cost-sharing designs reliant on UCR schedules. In February 2008, the New York State Attorney General issued a "Notice of Proposed Litigation"[100] to UnitedHealthcare, arguing that it based reimbursement on a defective UCR schedule developed by a sister company, Ingenix, resulting in under-reimbursement to policyholders for out-of-network care. A year later, Attorney General Cuomo announced a series of settlements with United and major health insurers in the state that contracted with Ingenix for data, ending what he called a "conflict-ridden system" in which insurers dictated payments, based on a flawed fee schedule they controlled.

The agreements, which varied depending on companies' use of Ingenix data, require them to contribute a total of over $90 million to a university-affiliated nonprofit organization

99 Cunningham PJ. September 2008. Trade-offs getting tougher: Problems paying medical bills increase for U.S. families, 2003-2007. Tracking Report No. 21. Center for Studying Health System Change.

100 Lacewell LA [counsel for economic and social justice, New York State Attorney General's Office]. February 13, 2008. Correspondence to Thomas J. McGuire, Esq., regional deputy general counsel, UnitedHealthcare; and New York State Attorney General's Office. February 13, 2008. Cuomo announces industry-wide investigation into health insurers' fraudulent reimbursement scheme. [Press release]

that the Attorney General's office will select, to establish a new database for use by insurers for their UCR products. Some health plans agreed to use the database for specified periods, and others have the ability to be "excused" by the Attorney General. Several health plans agreed to make payments to underpaid consumers and health care providers, either as a result of the settlements or due to separate class actions filed in many states.[101]

It's unclear how the settlements will affect the use of UCR arrangements in the future. If reimbursements for consumers and health care providers are higher under the new schedule, health plans will likely boost premiums for the benefit.

Consumer-Directed Products. So-called "consumer-directed health plans" (CDHPs) combine high-deductible coverage, tax-favored savings accounts, and tools to help consumers make informed decisions about their care, all in a bid to control costs. Proponents — and there are legions of them — argue that only when consumers have "skin in the game" — out-of-pocket costs they can avoid with smart health shopping — will costs be controlled. The most common among similar arrangements are known as High Deductible Health Plans/Health Savings Accounts (HDHP/HSAs). In order to be eligible for the tax subsidy, the policies must have minimum deductibles of $1,150 for individuals and $2,300 for families, but can be sold regardless of whether employers or employees contribute to the accounts. In fact, a recent report found that 39 to 42 percent of enrollees in HSA-eligible plans did not open an HSA.[102]

Despite relentless marketing, the new designs are facing strong resistance in New York. Health plan officials in upstate markets report particularly slow take-up. A recent industry survey[103] found that New York, with total enrollment in HDHP/HSA products of 127,665 in January 2008, ranked 47th among states in the proportion (1.1 percent) of privately insured individuals enrolled in these plans, just ahead of West Virginia (1.0 percent), Massachusetts (0.9 percent), and Hawaii (0.1 percent). Some brokers reported that HDHP/HSAs are gaining a foothold as a third option, as noted earlier, in traditional core/buy-up plans, under which employers can save on premiums, even after making contributions to employee HSA accounts.

Most health plans offer many products, not just HSA-eligible designs, with consumer-directed or wellness features such as 24-hour nurse hotlines, tools to create online personal health records, access to WebMD, health risk assessments tools, bonuses for healthy lifestyle activities (yoga classes, gym discounts), and the like. Legislation adopted in 2008[104] formally authorizes discounts and wellness programs that, to a large degree, were already in place, and sets some ground rules.

In terms of more substantive consumer-directed health care tools, Aetna, United-Healthcare, and Cigna are leaders. Aetna's "DocFind" program allows members to access information about health care providers' rates; its Aexcel program provides quality and efficiency information. UnitedHealthcare's UnitedHealth Premium Designation and Cigna's CignaCare Network also give enrollees and employer groups the ability to choose providers based on internal company measures of quality and efficiency, sometimes in conjunction with higher reimbursement rates for using preferred physicians or specialists.

101 Various Assurances of Discontinuance between the Office of the Attorney General and health plans, January to March, 2009, and accompanying press releases. http://www.oag.state.ny.us/bureaus/health_care/HIT2/reimbursement_rates.html.

102 U.S. Government Accountability Office. April 1, 2008. GAO-08-474R Health Savings Accounts.

103 AHIP Center for Policy and Research. April 2008. January 2008 census shows 6.1 million people covered by HSA/High-Deductible health plans.

104 Chapter 592 of the Laws of 2008.

In an outcome cheered by provider groups, which view the private "doctor ranking" programs with suspicion, the New York State Attorney General's Office signed agreements in 2007 with virtually all major health plans in the state — whether they incorporated physician ranking systems in their plan designs or not — that set standards for accuracy, transparency, and fairness of ranking systems, and require the appointment of an independent Ratings Examiner to oversee compliance with the guidelines and report semiannually to the Attorney General.[105]

Employer groups face a dizzying variety of products, many with slight variations (see sidebar, "Small Business, Many Options"). Officials at HealthConnect estimate that over 40,000 product variations are available in the tristate and downstate markets to small employer groups alone. One executive at a major downstate health plan noted, however, that "we offer hundreds of different products, but enrollment is in twenty-five or thirty of them, and it's mainly EPOs." While some observers blame health plans for flooding the market with all the products, health plans see themselves as working to gain an edge in an intensely competitive market, and as the handmaidens of their customers, who are sometimes capricious but almost always looking to reduce costs.

Rating and Rates: Determining How Much Buyers Pay for Coverage

The prices individuals and families pay for coverage are determined by the formulas health plans use to price risks, subject to New York laws and regulations, which vary depending on the market, the product, and the license under which it's sold. Health plans and state regulators call this process "rating," and the end product "premium rates."

Rating

Health plans and insurance regulators use the term "rating" to describe how the premiums for health coverage are set, a process in which health plan actuaries develop the price for a wide range of products based on the risks of the underlying population and on statutes and regulations that vary from state to state. Different rules can apply for both different categories of licensees and different insurance markets. While many view New York's rating structure as an either/or proposition — either community-rated or experience-rated — the state's rating methods fall into *four* categories: community rating, "book" or "manual rating," partial experience rating, and experience rating.

Rating Manuals. New York regulates rating through its authority to approve "rating manuals" that companies submit for approval. For community-rated markets — Direct Pay, Healthy NY, Small Group, and Large Group HMO products — health plans file schedules of monthly rates for products by policy form, with premium levels differing according to cost-sharing, riders, family size, and region. For experience-rated markets, mainly employer groups of over fifty employees, health plans submit complex formulas describing how rates are set. Health plans can offer rates that are in effect for a year, but more often submit rolling rates that are revised upward each quarter. Rates will vary depending on when an employer group renews or purchases insurance during the year.

Rating manuals are public records, subject to FOIL, that consist of several volumes — over 1,000 pages for some larger health plans. Since rating rules differ for different kinds of

105 In the matter of Connecticut General Life Insurance Company and Cigna Healthcare of New York, Inc., agreement concerning physician performance measurement, reporting and tiering programs. http://www.oag.state.ny.us/media_center/2007/oct/oct29a_07.html.

licensees, some health plan holding companies submit different manuals for each licensee in the corporate family. Health plans submit whenever circumstances require, but usually not less than annually, and also file reports of claims experience each May, so that the assumptions made in the formulas can be tested by state regulators. In 2007, the Department's Health Bureau reviewed over 1,400 filings.

Community Rating. Although sometimes viewed as an "alien" rating system that was imposed on New York in 1992 with the adoption of the Community Rating/Open Enrollment (CR/OE) law,[106] community rating was the basis for the premiums paid by perhaps 70 percent of the insurance market in New York at the time the law was passed (see Appendix E for more background and an assessment of New York's CR/OE law).[107] The effect of the law was to set guidelines for the practice already being used by Blue Cross plans and some HMOs, and to mandate that rates for individuals and Small Group coverage (three to fifty employees, later changed to two to fifty) issued by all Article 43s, HMOs, and Article 42s conform to the rules of the rating system.

Community rating is rating at its simplest, defined as "a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, or occupation." The law permits health plans to vary rates for individuals and families and to establish separate rating pools for individual policies and Small Group policies. Separate community rates are also permitted for "reasonable geographic regions," so long as they are no smaller than a county and

106 Chapter 501 of the Laws of 1992.

107 Curiale SR [New York State superintendent of insurance]. September 15, 1994. Letter to Daniel J. McCarthy, Milliman & Robertson, Inc.

Small Business, Many Options

The table on page 51 shows a range of products available to a fictitious small business, "Jack Unlimited," located in Manhattan, with twelve employees, eight of whom have opted to participate in the company's health plan. The group is composed of two single employees, two employees covering a spouse, two employees covering a child, and two families. Options were selected to include a range of health plans active in the market, as well as different plan options. Where available, comprehensive prescription drug coverage was selected as an optional benefit.

For ready insights into some of the most troubling issues in the insurance market today, a look at the range of product options available to this small business is a good start. These offerings illuminate four important "whys":

- Why health care providers are in despair at the multitude of confusing reimbursement schemes they confront daily in treating patients;
- Why, with annual costs ranging from $53,000 to $167,000 for this fictitious but typical company, small businesses despaired long ago about finding affordable coverage;
- Why businesses turn to producers to help them sort through complicated options; and
- Why national surveys show that employee costs for coverage, through higher deductibles and cost-sharing features, have doubled over the past nine years.*

The three lowest-premium products available, Plan M (Oxford HSA), Plan H (GHI EPO), and Plan A (Aetna HMO), deliver premium savings through different means. The Oxford product's higher deductibles make it eligible for use with an HSA. Individuals have,

continued on page 52

* *2008 Health Benefits Survey.* Washington, DC: Kaiser Family Foundation and Health Research and Educational Trust.

Selected Health Coverage Options for "Jack Unlimited"

	Plan	Type	Gen. Deductible In-Network	Gen. Deductible Out-of-Network	Coinsurance In-Network	Coinsurance Out-of-Network	Co-Pay	Monthly Premium
A	*Aetna*	HMO	None	N/A	N/A	N/A	$20/$40[1]	$4,916
B	*Aetna*	PPO	$2K/$6K[2]	$2K/$6K	80% $2K/$6K max[3]	60% w/80% UCR[4] $4K/$12K max	$25/$50 IN[5]	$5,964
C	*Cigna*	POS	None	$4.5K/$9.5K	None	50% w/80% UCR $6K/$12K max	$25/$40 IN[5]	$10,131
D	*EBCBS*	HMO	None	N/A	None	N/A	$10	$9,603
E	*EBCBS Prism*	EPO	None	N/A	None	N/A	$25	$6,144
F	*EBCBS*	PPO	None	$1K/$2.5K	None	70% w/70% UCR $7.5K/$18.7 max	$30 IN[5]	$13,890
G	*GHI*	PPO	None	$.5K /$1.5K	None	80% w/80% UCR $2K/$6K max	$20 IN[5]	$11,659
H	*GHI*	EPO	$2K/$6K	N/A	80% $3K/$9K	N/A	$40	$4,890
I	*HIP*	HMO	None	N/A	None	N/A	$20/$30	$5,951
J	*Health Net*	POS	None	$1K/$2K	None	70% w/80% UCR $5K/$10 max	$15/$30 IN[5]	$9,824
K	*OHP*	POS	None	$2K/$5K	None	70% w/70% UCR $1.5K/$3.75K max	$10 IN[5]	$11,897
L	*OHP*	POS	$2K/$4K	$2K/$4K	80% w/UCR 70% $2K/$4K max	60% w/70% UCR $4K/$8K max	$30 IN[5,6] OON coins.	$5,340
M	*OHP*	HSA	$2.8K/$5.7K	$2.8K/$5.7K	90% w/UCR 70% $3.8K/$7.7K max	70% w/70% UCR $5.8K/$11.7K max	IN/OON[5,6] Coins.	$4,383

1 $20/$40 indicates $20 co-payment for primary care/$40 for specialists.
2 $2K/$6K means a $2,000 deductible for individuals and a $6,000 deductible for families.
3 $2K/$6K means a $2,000 maximum coinsurance liability for individual coverage and a $6,000 maximum coinsurance liability for family coverage for in-network coverage.
4 The health plan reimburses at a rate equal to 60% of the amount that represents 80% of its Usual, Customary and Reasonable fee schedule for a particular service.
5 IN means In-Network; OON means Out-of-Network coverage.
6 Instead of co-pays, members pay coinsurance for visits, subject to policy maximums.

Source: United Hospital Fund analysis of HealthConnect quotes on 9/24/08, for rates effective 10/01/08. Rates based on a four-tier rate for two individual employees, two employees covering spouses, two individual employees with children, and two families.

Small Business, Many Options

(*continued from page 50*)

potentially, responsibility for about $4,000 in in-network treatment costs, and an additional $4,000 for out-of-network care, in addition to co-payments. If an HSA is in place along with the coverage, out-of-pocket expenses can be offset by withdrawals from the tax-free account.

Aetna's Plan A, the new New York City Community Plan, targeting small business, features no deductibles and modest co-payments. An enrollee unlucky enough to require inpatient admission, inpatient surgery, outpatient surgery, ER care, inpatient mental health treatment, or inpatient substance abuse treatment, however, would be liable for $3,400 in additional co-payments. The plan also includes a $3,000 maximum on prescription drugs.

GHI's plan H, an EPO, has the second-lowest premium in the group, with some savings achieved through a $2,000 deductible. The plan offers no out-of-network benefits, and in-network utilization carries up to an additional $3,000 for coinsurance. The use of coinsurance for in-network care in PPOs and EPOs is a more recent development. Most PPO plans previously imposed no out-of-pocket costs on enrollees for in-network care, other than nominal co-payments.

Plans D (Empire HMO) and I (HIP HMO) illustrate how comprehensive HMO coverage is no longer the bargain-basement product formerly offered by employer groups. While HIP, which typically occupies the low price-point region of the market, is still a lower-cost option, it comes in at nearly an identical premium to Aetna's Plan B, a PPO product with an out-of-network benefit. Similarly, Empire's HMO product (Plan D) comes in at a premium comparable to Health Net's POS product (Plan J), which also offers out-of-network benefits. Subscribers to the Empire HMO product face only $35 ER co-pays, in addition to $10 for doctor visits; HIP HMO enrollees cough up $200 for hospital admissions, $75 for ER visits, and $20 or $30 for office visits.

Empire's Plan E, the new Prism product, illustrates why its competitors are scratching their heads and asking, "How'd they do that?" With no deductibles or coinsurance, co-pays waived for routine primary and preventive care, a good drug benefit, and an overall out-of-pocket maximum of $1,000 for hospital and surgical services, it falls into the lower tier of monthly premium rates.

For this illustration all deductible and coinsurance out-of-pocket costs were calculated for individuals; they increase exponentially for family coverage, particularly when applied to both in-network and out-of-network benefits. Under Oxford's Plan L, a POS plan, families could incur sizeable out-of-pocket costs. Since actuaries typically calculate that 90 percent of utilization in plans offering out-of-network benefits occurs with in-network providers, families are unlikely to hit both in-network and out-of-network maximums. But in this example, if both maximums *were* reached, family out-of-pocket contributions of $20,000 could be required.

approved by the Insurance Department. Health plans submit schedules of community rates with their rate manuals each year.

While community rating of individuals and small groups is mandatory in New York for all licensees, any health plan may voluntarily community rate Large Group employers. Blue Cross Blue Shield plans continue to do so to some extent, although that business is evaporating due to market pressures.

Only Article 44s are required to community rate traditional HMO products for the Large Group market. That requirement is another example of some unsettled regulatory issues between HMOs and state officials. The obligation to community rate Large Group products is somewhat in flux, since underlying regulatory provisions refer to the CR/OE law, which only applies to small groups. In addition, if an out-of-network benefit is included, usually in a POS product, the products can be experience rated. As noted earlier, many health plans are offering managed care look-alike products, which are not subject to the Large Group community rating requirement.

In the Insurance Department's Regulation 145,[108] which implements the CR/OE law, key provisions deal with how health plans aggregate the claims experience of their insured population into a pool that will determine the community rate. While the statute applies to individual policy forms or contracts, the regulation requires health plans to combine the experience of different policies sold when they provide "substantially similar benefits." Under the regulation, contracts with differences related to deductibles, coinsurance amounts, the number of days or visits covered, or addition or deletion of benefits that do not substantially alter premiums are still considered substantially similar, and the experience must be pooled to develop a premium rate.

While health plans vary slightly in how they implement the community rating provisions, in practice rates are developed by aggregating claims experience under major product categories. HMO products are usually pooled separately from PPO or indemnity products. Total claims costs in the previous year for all the contracts or forms within the product category are added up (along with health plan administrative expenses, profits, etc.) and divided by the number of people covered under the policies in a given year. This figure is often called the "claims PMPM" (i.e., per member per month). This claims PMPM is then adjusted to reflect "trend" or expected changes in medical costs. Expected administrative expenses and profits are added in, and premium totals are then adjusted for the varying levels of benefits and cost-sharing, and optional riders that consumers may choose under the separate contracts. Although different levels of benefits and utilization are reflected in the premiums for each contract, rates on differing levels may not vary due to differences in the risks of policyholders. Plan A might have a lower rate than Plan B because the actuarial value of the benefit design is lower, but not because Plan B's enrollees incur more claims than those of Plan A.

As part of an investigation into health plans' adherence to minimum medical loss ratio standards, in 2008 the Insurance Department began reevaluating how health plans combine various products and pools. State regulators are concerned that health plans are reporting in a way that disguises loss ratios well below statutory minimums for some products. Health plans argue that they are following the law and regulations, and that aggregating policy forms does exactly what the law intended — provide a premium subsidy to high-loss ratio products from lower-loss ratio products. The resolution of this

108 11 NYCRR Part 360.

ongoing dialogue could alter how the law is implemented going forward.

Tiers. New York's health plans use "tiers" to differentiate rates to be paid by different sizes of families for both individual and group coverage. Although two-tier rates for individuals and families were once the norm, health plans, led by for-profit insurers, have moved to three-tier and four-tier rate structures. Three-tier rates typically include: 1) individual, or employee; 2) "two-party" or "double"; and 3) family. Four-tier rate structures typically include: 1) individual, or employee; 2) an individual/employee and spouse; 3) an individual/employee and his or her child or children; and 4) family.

Under a two-tier rating structure, smaller families subsidize larger families. Four-tier structures provide lower rates for a parent/child family than for an individual/employee and spouse family, but the lowest subsidy for larger families. Individual rates do not vary across tier systems. In the group market, health plans sometimes make all three rating structures available and allow the employer group to choose, but sometimes limit options within a given region. A four-tier structure has become the most common, in part because in a rate-conscious market it provides more targeted rate differentiation (see Table 6). Some employer groups, particularly public employees and unions, still maintain two-tier systems.

Regions and Area Factors. Following tiers, regional "area factors" are the most elemental way that health plans alter rates for both community- and experience-rated contracts. Claims experience under the groups of policies is aggregated into the respective regions. Regions can be defined by where members receive their care, where members reside, or where the employer group is located. The regional components must be consistent with laws and regulations and approved by the Insurance Department. Regions containing less than one county, for example, are prohibited. Area factors are then developed by reviewing the claims costs by region and also considering expected cost differences by region. For rating purposes, health plans then apply these area factors to a base rate to reflect varying costs of arranging for health services in a single county or a group of counties.

For a community-rated HMO product, for example, Empire BlueCross divides its 28-county territory into three regions: New York (New York City's five counties, plus Nassau, Rockland, Suffolk, and Westchester counties); Mid-Hudson (Dutchess, Orange,

Table 6. **Varied Tiers, Varied Rates**

Here's an example of how rates vary among the three tier structures for a community-rated Empire BlueCross HMO product in the New York City area.

Two-Tier Option		Three-Tier Option			Four-Tier Option			
Single	Family	Single	Two-Party	Family	Single	Couple	Parent/Child	Family
$392	$1,020	$393	$767	$1,137	$392	$784	$705	$1,176

Source: Empire HealthChoice HMO, Inc. *2007 Rate Manual.*

Table 7. **MVP's Seven-Region Differential**

Central 1	Central 2	Central 3	Mid-Hudson	New York Metro	East	North
1.051	*0.998*	*1.156*	*1.072*	*1.179*	*0.841*	*1.009*
			Counties			
Delaware Herkimer Lewis Madison Oneida Otsego	Cayuga Jefferson Onondaga Oswego	Broome Chenango Cortland Tioga	Dutchess Orange Putnam Sullivan	Rockland	Albany Columbia Fulton Hamilton Montgomery Rensselaer Saratoga Schenectady Schoharie Warren Washington	Clinton Essex Franklin

Note: The value "1" represents the base rate for MVP's PPO Select product.
Source: MVP Health Insurance Company rate manual.

Putnam, Sullivan, and Ulster counties); and Albany (Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties). The three pools produce three separate rates for a Small Group, community-rated, HMO product: Albany, $1,036; New York, $1,203; Mid-Hudson, $1,286. [109]

For other products, Empire assigns each of the twenty-eight counties area factors ranging from 0.76 (Schenectady County) to 1.10 (New York County [Manhattan]). Oxford establishes community rates based on claims experience in its fourteen-county service area extending from New York City north to Ulster County upstate. Within those fourteen counties, eight separate regions produced rates for an EPO product, in 2008, that ranged from $905 for a family in Ulster County to $1,131 for a family in Manhattan.[110] CDPHP organizes the twenty-four counties in its service area into four regions for its HMO products and five for its Article 43 products, the fifth rating territory comprising four counties in the Southern Tier. Area factors range from 1.0 in eleven counties in the Capital Area to 1.25 in Orange and Ulster counties.

For its Article 42-licensed Small- and Large Group PPO Select product, MVP Healthcare split its rating territory into seven different regions, with different cost factors, for 2007. As shown in Table 7, Albany-region enrollees pay nearly a third less in premiums than Central 3 and New York Metro groups.

HealthNow recently won approval to split off two counties from the part of its service area in Northeast New York, after a three-year effort with regulators. As a result, 2010 rates in rural Clinton and Essex counties will be 25 percent higher than in counties to the south.

Slicing up rating territories into ever smaller geographical areas is a growing

109 Empire HealthChoice HMO, Inc. Rating manual.

110 Oxford Health Insurance, Inc. Rating manual.

trend among health plans, as they carefully analyze the impact of higher costs in one area of a rating territory on the rates they charge for the entire territory. "It has to be worth it," said one upstate plan actuary — but if a competitive gain can be achieved, or a competitive disadvantage mitigated, health plans commit resources to reshuffling rating territories and area factors, often on a yearly basis. The Insurance Department and state Department of Health review health plans' actuarial justifications for changes and check to make certain that rating configurations are based on reasonable actuarial assumptions. Since Insurance Department regulations require that the regional rates for HMOs be "based on the different costs of providing health services in the respective regions,"[111] area factors are likely a result of regional health care providers having strong bargaining positions with health care plans.

Experience Rating. Experience rating is limited to employer groups of fifty-one or more. While commonly understood to mean a premium based on the claims experience for an employer group, in practice it's more complex. For all but the largest groups, experience rates more often represent a *prediction* of what a rate should be, rather than a premium based on an employer group's actual experience. Most experience-rated formulas protect large groups from big jumps in premiums due to adverse claims experience through reinsurance mechanisms built into the formula for an additional fee.

Experience rates are based on complex formulas that are submitted to the Insurance Department in health plans' rating manuals. Plans also make periodic "experience filings" — detailed summaries of claims experience — to support the assumptions contained in the formulas. The Department reviews the manuals to assure that those assumptions are borne out by the claims data submitted, comply with statutory and regulatory provisions, and produce rates that are sufficient to maintain solvency and loss ratio standards. While adjustments and other components in the rating formula give health plans some flexibility to structure a better deal for a preferred customer, plans are expected by regulators to apply the formulas fairly and equally to all employer groups. During triennial examinations of health plan books — onsite audits that can last a year — the use of the formulas is one area that is reviewed by state auditors, who frown on health plans deviating from the formulas filed with the Department.

Experience rating formulas often involve more than thirty separate mathematical calculations to set the final rate a customer will pay, but they begin with the community rate, the average costs of all customers buying the product in a region. Successive calculations adjust that basic rate to reflect an individual employer's mix of singles and families, other demographic information, and past claims history; whether the contract is a renewal or a transfer from another health plan; and optional riders and benefits, taxes, broker commissions, health plan administrative expenses, surplus contributions and profits, medical trend factors (predictions of how utilization and medical costs change from the previous year), and different kinds of "pooling charges" (stop-loss mechanisms that are used to "smooth out" an employer group's catastrophic claims in a given year).

Most formulas include minor adjustments at the tail end, based on such characteristics as the employer group's "creditworthiness," the percentage of employees participating in the plan, and the length of time they've been insured through the health plan. The extent to which the employer group's rate in a given year actually reflects its claims in given years depends on two variables: the type of experience-rated contract it chooses, and the

[111] 11 NYCRR 52.42(d)(2).

credibility factor the health plan uses to assess whether previous claims experience is a reliable or credible predictor of future claims experience.

The two main types of experience-rated contracts are prospective and retrospective. Under a prospectively rated contract, used most often by smaller large groups, the health plan sets a rate based on its best actuarial assumption of the claims the employer group will incur the following year. No adjustment is made to the premium if the employer group incurs either fewer or more claims that year. Under a retrospectively rated contract, the health plan sets an initial rate for the year but both sides agree to "true up" the premium based on the employer group's actual claims experience. If the employer group's claims are lower than predicted, the health plan will pay a refund or dividend to the employer group; higher-than-anticipated claims require the employer group to contribute additional premium.

A third and even more aggressive option is known as a minimum premium plan, or MPP, often made available to employer groups as a rider to an experience-rated contract. Developed by MetLife in the 1960s to mollify a large employer complaining of added costs from state premium taxes,[112] MPPs permit employer groups to pay monthly premiums that might be one-third of the cost of a premium under a traditional experience-rated contract, while depositing separate funds, based on each month's actual claims experience, with the health plan. Minimum premium plans — widely available in the market — are viewed by health plans as a way to test a client's appetite for risk, and the penultimate stage in a continuum that ends with employer groups deciding to self-fund health benefits.

112 Eliers RD. March 1969. Minimum premium health plans: Insured non-insurance. *The Journal of Risk and Insurance* 36(1): 63-84.

Table 8. **Credibility Factors — Two Examples**

MVP Insurance Co. Large Group Credibility Factors		Excellus Health Plans, Inc. Standard Credibility Table	
Average Subscribers Per Month	**Credibility Factor**	**Number of Employees**	**Credibility Factor**
51-75	35%	51-74	0.35
76-100	45%	75-99	0.42
101-150	55%	100-124	0.47
151-200	65%	125-149	0.52
201-250	75%	150-174	0.57
251-300	85%	175-199	0.61
301-350	90%	200-249	0.67
351-399	95%	250-299	0.74
≥ 400	100%	300-349	0.81
		350-399	0.87
		400-449	0.92
		450-499	0.97
		500+	1.00

Source: Rating manuals filed with New York State Insurance Department.

Credibility Factors. Setting a credibility factor is among the most important financial decisions health plans make in determining the basis for the rates their customers will pay, and, by extension, the health plan's financial success. Credibility tables, filed with rating manuals, set out the degree claims experience will be used to determine rates, based primarily on two variables, the size of the employer group or number of employees enrolled in the plan, and how far back claims experience for the company is available. Credibility factors vary among health plans and sometimes among their own products and licenses, but most plans use full experience rates for employers with at least 400 or 500 workers. Health plan credibility tables vary regarding the point at which claims experience becomes a significant part of the rate.

Neither HIP nor Empire HealthChoice Assurance, Inc., Empire's Article 42 licensee, uses claims experience for employer groups of less than a hundred.[113] Oxford gradually phases in claims experience for groups of seventy-five or more, based on the length of time they've been insured. The credibility tables in Table 8 represent a more aggressive approach, factoring in claims experience beginning at the minimum required for large groups, fifty-one or more workers.

Since claims experience represents a proportional factor in rates, ranging from 0 percent to 100 percent based on the size of the employer group, just how do health plans develop rates for the groups falling between community rating and full experience rating? They do that by using factors prohibited, under the CR/OE law, for individuals and small groups — age, sex, and industry.

Book Rates. Book rates, also known as manual rates or adjusted community rates, are used by health plans to set an entire rate for smaller groups or flesh out a rate for groups not fully experience-rated. The age and sex of enrollees, which actuaries consider to be the most accurate predictors of future claims experience, and the type of industry enrollees are engaged in are three principal factors used to derive these manual rates. Two health plans' age and sex rating tables are shown in Table 9, one of which features a "unisex" rate factor (unrelated to its operations in New York) alongside the usual age and sex factors. When setting book rates, values in the age and gender columns are used to multiply the base rates of each group to achieve a rate reflecting the age and sex of an employer group's workers.

For family contracts, rate swings related to gender and age are moderated, since most family tiers include a mix of old and young, and of male and female. For both individuals and family tiers, health plans generally calculate an average age/sex factor for the employer group, which is then applied to the base rate to arrive at the premium the group will pay. See Table 10 for examples.

Industry Factors. The type of work a firm does is a third factor that goes into developing rates. Although the use of industry factors is not permitted in New York's community-rated markets, they are universally used for Large Group rates, and are derived from statistical categories used by the federal government.

Developed in the 1930s to promote uniformity in data collection by federal agencies, the Standard Industrial Classification (SIC) system categorizes all "establishments" through four-digit codes. The SIC groups over 1,000 different kinds of economic activity into ten categories known as "divisions," such as "agriculture, forestry, and fishing" and "mining." Types of activities within divisions are differentiated by tacking on additional digits to further define the categories. Within the agriculture/crops category, for example, wheat farming is 111 and tree nut farming

113 When interviewed in 2008, Empire BCBS officials indicated that they were awaiting State Insurance Department approval of a new credibility formula that would phase in claims experience for smaller groups.

Table 9. **Age and Sex Rating Factors – Two Examples**

CDPHP Universal Benefits, Inc.

Age Band	Male	Female	Unisex
<20	0.508	0.508	0.508
20-24	0.537	0.815	0.686
25-29	0.573	1.066	0.852
30-34	0.547	1.150	0.861
35-39	0.578	1.067	0.838
40-44	0.726	1.055	0.901
45-49	0.888	1.174	1.038
50-54	1.103	1.489	1.300
55-59	1.543	1.569	1.556
60-64	2.247	2.034	2.137
65+	3.007	2.643	2.835

Empire HealthChoice Assurance, Inc.

Age Band	Male	Female
<20	0.450	0.813
20-24	0.450	0.813
25-29	0.433	0.838
30-34	0.576	1.117
35-39	0.812	1.214
40-44	1.041	1.135
45-49	1.150	1.251
50-54	1.302	1.323
55-59	2.115	1.603
60-64	2.620	2.172
65-69	3.311	2.204
70+	3.311	2.204

Sources: Rating manuals filed with the New York State Insurance Department by CDPHP Universal Benefits, Inc. (top) and Empire HealthChoice Assurance, Inc.

is 173. The North American Free Trade Agreement ushered in a new classification system, however, that most federal agencies now use, the North American Industrial Categorization System (NAICS, pronounced "nakes"). With twenty categories, it is more expansive, and is supplanting use of the SIC codes.

Health and life insurance companies either develop, or purchase from actuarial firms, data bases that break down long-time claims experience within different industries, and assign industry factors reflecting their average. These industry factors (with a value of 1 as the average claims experience) further adjust rates already reflecting an employer group's

Table 10. **Family Policy Age and Sex Factors**

Age Band	Male Age Factor	Female Age Factor
<20	0.866	0.836
20-24	0.866	0.836
25-29	0.943	0.895
30-34	1.082	0.901
35-39	1.082	0.936
40-44	1.066	0.883
45-49	1.008	0.962
50-54	1.080	1.131
55-59	1.277	1.312
60-64	1.599	1.926
65-69	1.699	2.471
70+	2.066	2.471

Source: Empire HealthChoice Assurance PPO Rating Manual.

age and gender mix.

Health plans include exhibits listing the industry factors in their rating manuals. A five-page table for Empire HealthChoice Assurance's Prism PPO is fairly typical of the industry factors many health plans use (Table 11).

At almost 100 pages, the industry factor appendix filed by MVP Health Insurance Company for the for-profit Article 42 licensee of nonprofit MVP Healthcare, Inc., is more detailed (Table 11). It contains a higher proportion of high-value factors, and a greater spread among factors (40 percent vs. 35 percent).

On the one hand, industry factors seem related to the occupational hazards of particular industries, and more properly a factor in workers' compensation coverage than in health insurance. But on the other, while actuaries cite high turnover rates among hotel workers, it is difficult to explain why hotels and uranium mining would share the same industry factor. While there is some controversy over the use of industry factors within the actuarial profession, they remain a cornerstone of experience rating, and another symbol of the trade-offs inherent in rating systems. A proponent of a socially oriented system might ask why bankers should pay less for health insurance than those who mow their lawns, clean their suits, or wait on their tables. A proponent of an actuarial approach would argue that orderly health insurance markets are dependent on accurately assessing each customer's risk, and pricing it accordingly.

Under book rates, until the point at which an employer group reaches the credibility factor used by the health plans, it will be age, sex, and industry factors that determine the rate charged the group. Firms employing more women, or older men and women, or doing certain kinds of work, pay higher rates after the differentials are applied to the base rate.

Partial Experience Rating

Once the credibility factor threshold is reached, demographic factors are blended with the group's claims experience to arrive at a partial experience rate. The weight that demographic factors or claims experience are given in developing the partial experience

rates is determined by where the employer groups fall in the health plan's credibility table. As Table 12 shows, however, a significant portion of the fully insured experience-rated market pays rates based wholly or in part on demographic factors, since actual claims experience is used to develop rates for larger groups.

The long-running discussion about the role of actuarial techniques in New York's markets plays out in an interesting way when small groups (fifty or fewer employees) and "small

Table 11. **Industry Factors**

Empire BCBS

Industry	Factor	Industry	Factor
Depository Institution	.90	Iron Ore Mining	1.25
Non-bank Credit Agency	.95	Non-Iron Ore Mining	1.20
Communication Services	.96	Beauty Shops	1.20
Computer Programming	.97	Drinking Places	1.20
Engineering/Architecture	.99	Oil/Gas Extraction	1.15
Transportation Services	.99	Taxicabs	1.15
Public Relations	.99	Eating/Drinking Establishments	1.12
Management Consulting	.99	Physical Fitness Facilities	1.11
		Legal	1.10

Source: Empire HealthChoice Assurance, Inc. Rating Manual for Prism PPO product.

MVP Health Insurance

Industry	Factor	Industry	Factor
Federal Reserve Banks	.85	Iron Ore Mining	1.25
Commercial Banks	.85	Uranium Mining	1.25
Pawnshops	.90	Beauty Salons/Barber Shops	1.25
Tree Nut Farming	.90	Drycleaners	1.25
Life/Health Insurers	.90	Police Protection	1.25
Engineering	.90	Fire Protection	1.25
Architecture	.90	Bowling Alleys	1.25
Libraries	.90	Hotels	1.25
Reducing Maple Sap to Syrup	.90	Liquor Stores	1.25
Certified Public Accountant	.95	Logging	1.25
Bank Holding Companies	.95	Explosive Manufacturing	1.25
Computer Programming	.95	Snack Bars w/o Alcohol	1.25
Computer Systems Design	1.0	Independent Artists/Writers	1.25
Legal	1.0	Government Exec./Legis.	1.20
Retail Bakeries	1.0	Doctor's Offices	1.20
Dairy Cattle and Milk Production	1.05	National Security	1.20
Convenience Store w/o Gas	1.05	Convenience Store w/ gas	1.15

Source: MVP Health Insurance Co. Inc. Rating Manual.

large groups" are compared. Rates for a small group with forty participating employees, for example, would be based on the experience of all employer groups buying that product in a given region — in essence, an experience rate for the rating pool. Rates for a small large group with, say, sixty employees but with the same number of forty participating members would be based largely or exclusively, depending on the plan, on the age and sex of the workers and the industry of the company.

Rates

The rates health plans charge for policies are overseen by the State Insurance Department for all licensees. While the Department once had the right to pass on most rates before they were charged to customers, the 1990s brought a gradual deregulation, as health plans won concessions during negotiations on major reforms such as the CR/OE and POS laws. Today, Article 42s, Article 43s, and HMOs operate under very similar rate systems.

As noted earlier, experience rates for groups of over fifty employees are based on the demographic characteristics and claims experience of individual businesses. As part of their rate manual filings for Insurance Department approval, health plans submit formulas describing how rates will be calculated. For individual and Small- and Large Group community-rated business, health plans have two options, "prior approval" or "file and use."

Under prior approval, plans submit proposed rates to the Department and wait for its approval before charging customers those rates. Under the file-and-use alternative, plans can file rates with the Department and begin using them right away, as long as they certify that the rates will result in a certain percentage of premium being paid out for medical services. Health plans that use the alternative procedure are required to report, in the following year, whether they hit their projected medical payment targets (known as minimum medical loss ratios, or minimum MLRs), and, if they don't, must make refunds to customers. Rates for new or revised products must have prior approval.

To be eligible for the alternative procedure, Article 42s must agree to 75 percent minimum medical loss ratios for their individual and Small Group customers. For Article 43s and HMOs, minimum MLRs are 80 percent for individuals and 75 percent for groups. An 80 percent minimum medical loss ratio means that 80 cents of every premium dollar are spent on medical treatment or claims, with 20 cents retained for administrative expenses and profits.

Table 12. **New York State Employer Groups by Firm Size and Employees**

Firm Size	Number of Firms	Number of Employees
51 to 100	8,750	608,071
101 to 150	3,020	369,311
151 to 200	1,474	254,551
201 to 250	908	202,744
251 to 300	591	161,545
301 or more	2,883	3,140,620

Source: New York State Department of Labor, December 2007.

While seeking prior approval means longer waits before rates can be instituted, there's a benefit to be gained, in lower minimum medical loss ratios. Article 42 commercial health plans are required to meet only a 60 percent medical loss ratio for group coverage and a 55 percent ratio for individual coverage.[114] The same standard applies to Article 43s and HMOs, except for a 15 percent cap on administrative expenses in place for Article 43s on their entire book of business.

Except for the minor difference in loss ratios, Article 43s and HMOs have obtained parity with their Article 42 competitors — although that took a while. The 1995 POS legislation permitted file-and-use rates only for increases below 10 percent, and phased down the loss ratio for individuals to 80 percent, from 85 percent, over five years. While state regulators recall that the 10 percent cap produced "a lot of 9.9 percent increases," the Insurance Department used its authority to restrain rate increases, particularly for Direct Pay customers, for whom rate increases typically exceeded the 10 percent threshold that triggered further review.

But the legislation also included a "sunset" provision under which Article 43s and HMOs would be permitted to file and use any rate increase, whatever the size, beginning January 1, 2000, unless the law was reauthorized. Although the Assembly voted each year beginning in 1999 to extend the law and restore the rate increase limitations, the state Senate chose to let them lapse — and stay lapsed.

For a time, according to a former state regulator, Insurance Department officials attempted to use "moral suasion" with health plans to keep rates for individuals within 150 percent of the premium paid for a comparable Small Group policy. With no action by the Senate on the legislation it submitted to restore review of rates, the Department instructed health plans to submit individual rate increases for approval. In a case that went to the state's highest court, Excellus sued to overturn the directive, arguing that it was inconsistent with the provisions of the POS law. The court agreed and, in 2004, the directive was struck down.[115]

Consumer groups believe that the Department's loss of prior-approval authority is behind the run-up of rates and insurer profits from 2000 to the present, and the healthy surpluses that health plans have accumulated. One former regulator noted that the Department "lost the ability to regulate based on the financial condition of the industry." Evaluating rate increase requests under the prior approval standard, the Insurance Superintendent could refuse approval if he or she found the rates "excessive, inadequate, or unfairly discriminatory" and could also "consider the financial condition of such insurer in approving or disapproving any premium."[116] In other words, the Superintendent was authorized to require health plans to use surplus funds to reduce rate increases that might otherwise be approved based on medical inflation or utilization trends.

Groups looking to restore prior-approval authority have an ally in the Paterson administration, which has advanced legislation to eliminate the file-and-use system and increase minimum medical loss ratios.[117] A memorandum in support of that proposal says the current system is "subject to manipulation and does not ensure that health plans set appropriate premium rates."

114 11 NYCRR Part 52.45.

115 In the matter of Excellus Health Plan versus Serio. April 6, 2004. http://www.nycourts.gov/reporter/3dseries/2004/2004_02513.htm.

116 NYIL Section 4308(b).

117 Bill and memorandum for A.8280-Morelle/S.5470-Breslin, introduced at the request of the Governor, May 12, 2009.

Health plans maintain that prior approval of rates leads to artificial rate suppression that can jeopardize plan solvency. They also argued that the Insurance Department would not be able to review rates in a timely fashion, leaving health plans without marketable products during open enrollment periods for employer groups. Finally, they viewed prior rate approval as exacerbating cost pressures created by the addition of new surcharges and taxes on health plan premiums as part of the FY 2009-10 state budget.

The Top Line and the Bottom Line: Health Plan Financial Results

Health plans' financial results — what they spend and what they keep from the premiums customers pay for their products — are reported in great detail in state regulatory filings, and are calculated in a number of ways. In this business, the "top line" refers to the premiums health plans collect, and the "bottom line" represents what's left over.

On the spending side, health plans report taxes, medical claims expenses, and administrative costs, and they calculate ratios of various categories of expense to overall premiums. On the other side of the ledger, the plans report revenues from premiums and other sources, investment income earned on premiums, net income, profit margins, and surplus. By almost any of these measures, despite escalating health care costs and declining commercial enrollment, most health plans did very well in New York's insurance markets in 2006 and the years immediately prior (Table 13).

Retention: What Health Plans Keep

Retention is the word health plans use to describe the amount of premiums or revenues they keep for their own administrative expenses, profits, and surplus, net of investment income.

Administrative Expenses. HMOs incurred administrative expenses of $1.33 billion in 2006, on items including salaries, marketing and advertising, computer systems, and agent and broker commissions (Table 14). Article 43 companies spent $1.5 billion, and Article 42s another $682 million, on administrative expenses. That's over $3.5 billion in all. On average, HMOs and Article 43s spent about 10.5 percent of their revenues on administration, and Article 42s about 8 percent.

On a per member per month basis, administrative expenses averaged $37 for HMOs, $23.89 for Article 43s, and only $9.57 for Article 42s, those lower costs perhaps reflecting product designs under which only out-of-network benefits are insured by the Article 42 licensee, and membership is concentrated in supplemental rather than comprehensive coverage.

Net Income. Net income is a calculation that reflects health plans' profits after accounting for two significant variables — subtracting taxes paid and adding investment income. Health plans reported $1.74 billion in profits in 2006. Of that total, HMOs reported $689 million, Article 43s $384 million, Article 42s $520 million, and prepaid health services plans $52 million. Illustrating the importance of public programs to their bottom lines, HMOs earned over 40 percent of their revenues from state public programs and Medicare, with the latter contributing $315 million to profit. Oxford/UnitedHealth Group was the most profitable company ($481 million), followed closely by Empire ($451 million), with HIP/GHI ($249 million), Excellus ($152 million), MVP/Preferred Care ($81 million), and HealthNow ($80 million) following.

Two other ways of looking at profits are "margin," which measures the ratio of profits to revenues, and net income per member per month, a calculation of profits for each covered member. Under both measures, health plans fared very well.

HMOs averaged a healthy 5.5 percent margin, Article 42s 6.2 percent, and Article 43s 3.5 percent. Oxford had the best year among HMOs and Article 42s, with margins of 9.9 percent and 10.9 percent, respectively. Margins at major Article 43s HIP (5.1 percent), Excellus (3.2 percent), and HealthNow (3.8 percent) were smaller but positive.

Net incomes measured on a PMPM basis averaged $19 for HMOs, $7.76 for Article 43s, and $7.26 for Article 42s. Reflecting its successful entry into the Medicare Advantage market, Managed Health, Inc., the HealthFirst HMO, posted the highest income PMPM at $42.92; Oxford also doubled HMO averages at $41.54. Among Article 43s, HIP also doubled the average, at $17.92; among Article 42s, Oxford led with a $10.89 return per member. Not every health plan made money. Cigna's HMO posted losses of over $20 PMPM, and MDNY had negative results of $25.68 PMPM. Cigna announced plans to close its HMO and focus on PPO products in 2008; MDNY closed its doors in 2007 and is being "liquidated," the regulatory term for winding up the affairs of an insolvent insurer.

Surplus. Also known as net worth, surplus is the term state regulators use to describe the amount by which a health plan's assets exceed its liabilities. State Insurance Law and State Department of Health regulations set different standards for the minimum surplus required of each of the three types of licensees delivering health care benefits.

Health Department regulations issued in 2005 require HMOs to increase amounts maintained in "contingent reserves" from 5 percent of annual net premium income to 12.5 percent over a seven-year period;[118] some health plans are currently at or above the required level. A similar standard is in place for Article 43 nonprofit insurers, which must maintain a "statutory reserve fund" of 12.5 percent of net premium income.[119] Article 42 health insurers are governed by the "Risk-Based Capital" (RBC) standards[120] of the National Association of Insurance Commissioners (NAIC). Those standards were developed to measure the risk to which a health plan is exposed, and the surplus necessary to lessen the chance of insolvency. Under the RBC formula, health plans must maintain ratios of 200 percent to be deemed sufficiently solvent not to require intervention by a state regulator.

While New York State mandates minimum levels of surplus, it does not mandate "maximum" levels of surplus for health plans. Domestic mutual life insurance companies, as well as stock life companies issuing policies with dividend benefits, have caps on the amount of surplus they may maintain.[121]

Most states have regulatory schemes for the evaluation of surplus that are similar to New York's. In Pennsylvania, regulators took a different approach, undertaking an exhaustive study of the surplus levels of the state's four BCBS plans, and a thoughtful look at what level of surplus is appropriate for nonprofit health plans. The investigation culminated, in 2005, with new standards for the surplus of the BCBS plans,[122] as well as a five-year agreement with the plans to make "Annual Community Health Reinvestments" equal

118 10 NYCRR Part 98-1.11(e).

119 NYIL Section 4310(d).

120 NYIL Section 1322.

121 NYIL Section 4219.

122 Determination of the Insurance Commissioner of the Commonwealth of Pennsylvania. February 9, 2005. http://www.ins.state.pa.us/ins/lib/ins/whats_new/2004bc/BCBS_DETERMINATION.PDF.

Table 13. **New York Health Plan Revenue and Net Income**

Article 44 HMOs	**Underwriting Revenue**	**Underwriting Net Income**	**Investment Income**	**Income Taxes**	**Net Income**	**Margin**	**Net Income (Loss) Per Member Per Month**
Aetna Health	936,016,005	76,472,596	13,253,841	28,282,466	61,443,971	6.6%	25.17
AmeriChoice	254,298,717	5,843,966	4,186,058	3,028,521	7,001,503	2.8%	5.12
Atlantis Health Plan	26,789,125	(1,446,517)	19,808		(1,426,709)	-5.3%	(13.21)
CDPHP	844,040,951	24,838,155	9,612,331		34,450,486	4.1%	11.15
Cigna Healthcare	117,231,928	(8,847,578)	1,963,796	289,626	(7,173,408)	-6.1%	(20.06)
ConnectiCare of New York	1,000,656	(14,930)	227,792	(88,991)	301,853	30.2%	829.27
ElderPlan	266,869,991	10,770,407	3,945,298		14,715,705	5.5%	73.24
Empire HealthChoice HMO	2,541,672,073	174,886,098	35,385,001	78,593,472	127,773,108	5.0%	18.33
GHI HMO	198,075,979	(5,482,223)	527,858	(798,114)	(4,156,253)	-2.1%	(5.58)
Health Net of New York	519,108,631	7,984,434	6,323,156	4,935,315	9,608,162	1.9%	4.65
Independent Health Association	996,048,490	42,156,452	13,225,138	685,000	55,872,063	5.6%	17.26
Managed Health Inc.	550,963,887	14,416,989	10,433,317		24,850,306	4.5%	42.92
MDNY Healthcare	94,168,238	(8,262,540)	144,603	1,254	(8,119,191)	-8.6%	(25.68)
MVP Health Care	952,837,761	2,257,582	9,554,177	727,561	12,225,187	1.3%	3.77
Oxford Health Plans	2,706,060,000	385,043,827	41,453,018	160,010,430	266,975,181	9.9%	41.54
Preferred Care	899,490,367	54,536,197	13,629,084	387,682	67,777,599	7.5%	28.44
UnitedHealthcare of New York	412,845,420	10,801,437	7,975,098	4,350,046	13,223,389	3.2%	9.63
WellCare of New York	296,370,887	16,407,617	4,220,526	6,915,438	13,712,705	4.6%	10.58
Subtotal	12,613,889,106	802,361,969	176,079,900	287,319,706	689,055,657	5.5%	19.03

Article 43 Nonprofit Insurers	**Underwriting Revenue**	**Underwriting Net Income**	**Investment Income**	**Income Taxes**	**Net Income**	**Margin**	**Net Income (Loss) Per Member Per Month**
CDPHP Universal Benefits	127,663,554	(1,373,523)	409,523		(964,000)	-0.8%	(1.96)
Excellus Health Plan	4,814,076,665	135,856,803	49,428,116	42,311,703	151,721,809	3.2%	6.70
Group Health Inc.	2,418,075,286	16,229,658	35,113,494	10,719,302	40,581,306	1.7%	2.09
Health Insurance Plan of Greater New York	4,073,366,864	158,557,565	28,448,866	4,989,028	206,574,665	5.1%	17.92
HealthNow New York	2,110,474,431	71,871,879	19,762,994	24,977,368	79,991,664	3. 8%	11.39
Independent Health Benefits	134,746,394	2,672,789	14,513,977	1,580,001	2,563,536	1.9%	4.26
Preferred Assurance	3,984,682	(14,344)	52,505	(219,595)	257,756	6.5%	1.59
Subtotal	13,682,387,876	383,800,827	147,729,475	84,357,807	480,726,736	3.5%	7.76

Table 13. **New York Health Plan Revenue and Net Income** (cont.)

Article 42 Accident and Health Insurers	**Underwriting Revenue**	**Underwriting Net Income**	**Investment Income**	**Income Taxes**	**Net Income**	**Margin**	**Net Income (Loss) Per Member Per Month**
Aetna Health Insurance of America	15,297,134	429,215	82 8,175	438,914	818,476	5.4%	1.29
Empire HealthChoice Assurance	5,277,652,195	289,294,018	108,962,446	117,682,265	322,991,815	6.1%	10.21
Health Net Insurance of New York	271,214,857	16,348,386	3,169,694	7,175,090	12,341,190	4.6%	10.61
HIP Insurance Company of New York	50,795,494	1,709,901	658,922	305,837	2,062,986	4.1%	2.40
Horizon Healthcare Insurance Company of New York	168,520,195	(29,604,480)	3,100,114	(4,595,273)	(18,509,093)	-11.0%	(23.26)
Humana Insurance Company of New York	130,929,846	(1,599,202)	571,935	(277,190)	(750,077)	-0.6%	(1.36)
MVP Health Insurance	49,033,727	1,304,464	1,087,868	17,300	2,375,032	4.8%	4.85
Oxford Health Insurance	1,454,823,759	205,298,495	27,596,769	75,498,854	159,257,366	10.9%	10.98
PerfectHealth Insurance Company	3,224,875	(4,232,198)	196,855	(1,231,361)	(2,275,775)	-70.6%	(105.75)
United HealthCare Insurance Company of New York	1,007,063,097	26,345,276	40,434,624	25,241,225	41,604,812	4.1%	1.97
Subtotal	8,428,555,179	505,293,875	186,607,402	220,255,661	519,916,732	6.2%	7.25
TOTAL	34,724,832,161	1,691,456,671	510,416,777	591,933,174	1,689,699,125	4.9%	9.95

Prepaid Health Services Plans	**Premium Revenue**	**Underwriting Net Income**	**Investment Income**	**Income Taxes**	**Net Income**	**Margin**	**Net Income (Loss) Per Member Per Month**
Affinity Health Plan	489,055,425	303,245	9,320,484		20,439,430	4.2%	8.12
Amerigroup	266,951,449	13,504,652	2,638,384	10,065,256	10,730,910	4.2%	8.32
Centercare	154,477,239	(1,732,634)	1,342,426		(1,209,105)	-0.8%	(1.35)
Community Premier Plus	164,074,517	(3,888,649)	884,969		(7,454,029)	-4.5%	(8.08)
HealthFirst PHSP	828,816,756	9,500,220	6,479,456		11,390,961	1.4%	2.58
HealthPlus	592,355,371	3,013,457	5,198,226		14,600,491	2.5%	4.59
Hudson Health Plan	151,816,764	197,493	1,451,879		496,669	0.3%	0.70
MetroPlus Health Plan	581,251,983	18,721,428	5,110,545		(2,400,783)	-0.4%	(0.81)
Neighborhood Health	236,291,863	20,801,414	3,236,503	(495,000)	(11,883,875)	-5.0%	(9.61)
NewYork-Presbyterian	149,879,219	(4,043,252)	2,015,975		(4,538,587)	-3.0%	(6.07)
NYS Catholic Health Plan (Fidelis Care)	580,039,655	(3,003,304)	9,179,363		17,432,481	3.0%	5.50
SCHC Total Care	54,129,085	511,987	575,139		892,909	1.6%	3.08
Suffolk County	36,127,910	(1,376,314)	604,295		465,175	1.3%	2.55
Univera Community Health	74,313,457	3,601,537	491,923		3,132,578	4.0%	6.96
Subtotal	4,359,580,693	56,111,280	45,399,260	9,570,256	52,095,225	1.2%	2.25

Source: Author's analysis of health plan and insurance company annual statements, Statement of Revenues and Expenses; and Medicaid Managed Care Operating Reports to Department of Health. Based on underwriting revenues and expenses, not including investment income or income taxes.

Table 14. **Administrative Expenses for New York Health Plans, 2006**

Article 44 HMOs	**Administrative Expenses**	**As a % of Revenues**	**As a % of Expenses**	**Per Member Per Month**
Aetna Health	105,651,094	11.3%	12.3%	43.28
AmeriChoice	39,061,013	15.4%	15.7%	28.58
Atlantis Health Plan	9,773,942	36.5%	34.6%	90.48
CDPHP	91,148,487	10.8%	11.1%	29.50
Cigna Healthcare	15,666,380	13.4%	12.4%	43.80
ConnectiCare of New York	928,124	92.8%	91.4%	2,549.79
ElderPlan	43,588,176	16.3%	17.0%	216.95
Empire HealthChoice HMO	242,215,742	9.5%	10.2%	35.66
GHI HMO	25,139,199	12.8%	12.5%	33.73
Health Net of New York	89,468,685	17.2%	17.5%	43.26
Independent Health Association	86,810,414	8.7%	9.1%	26.82
Managed Health Inc.	75,500,917	13.7%	14.1%	130.42
MDNY Healthcare	15,235,966	16.2%	14.9%	48.19
MVP Health Care	107,396,676	11.3%	11.3%	33.14
Oxford Health Plans	218,639,600	8.1%	9.4%	34.01
Preferred Care	63,566,441	7.1%	7.5%	26.68
UnitedHealthcare of New York	44,007,073	10.7%	10.9%	32.04
WellCare of New York	61,629,083	20.8%	22.0%	47.57
Subtotal	1,335,427,012	10.6%	11.3%	37.07

Article 43 Nonprofit Insurers	**Administrative Expenses**	**As a % of Revenues**	**As a % of Expenses**	**Per Member Per Month**
CDPHP Universal Benefits	12,433,183	9.7%	9.6%	25.34
Excellus Health Plan	488,835,071	10.2%	10.4%	21.59
Group Health Inc.	261,233,028	10.8%	10.9%	13.46
Health Insurance Plan of Greater New York	493,830,644	12.1%	12.6%	42.84
HealthNow New York	208,874,535	9.9%	10.2%	29.74
Independent Health Benefits	12,387,119	9.2%	9.4%	20.58
Preferred Assurance	654,984	16.4%	16.4%	4.03
Subtotal	1,478,248,564	10.8%	11.1%	23.89

Article 42 Accident and Health Insurers	**Administrative Expenses**	**As a % of Revenues**	**As a % of Expenses**	**Per Member Per Month**
Aetna Health Insurance of America	521,795	3.4%	3.5%	0.82
Empire HealthChoice Assurance	279,049,364	5.3%	5.6%	8.82
Health Net Insurance of New York	47,751,217	17.6%	18.7%	41.05
HIP Insurance Company of New York	6,469,156	12.7%	13.2%	7.54
Horizon Healthcare Insurance Company of New York	30,650,810	18.2%	15.5%	38.53
Humana Insurance Company of New York	11,635,805	8.9%	8.8%	21.05
Oxford Health Insurance	179,500,999	12.3%	14.4%	12.37
PerfectHealth Insurance Company	5,745,784	178.2%	77.1%	266.98
United HealthCare Insurance Company of New York	120,653,531	12.0%	12.3%	5.72
Subtotal	681,978,461	8.1%	8.7%	9.57

Source: Author's analysis of health plan annual statements, Statement of Revenues and Expenses.

to a portion of their premiums.[123] A report commissioned by Pennsylvania's Legislative Budget and Finance Committee[124] provides a good overview of the issues of surplus and community benefits.

From a regulatory perspective, maintaining adequate minimum surplus levels protects policyholders and health care providers from unexpectedly high claims costs. Adequate reserves are especially important in New York, as state laws do not establish guaranty funds to pay the claims of insolvent HMOs and nonprofit insurers, as some states do, and as is the case with most other kinds of insurance.

Health plans have many other uses for surplus, beyond solvency regulation. Regional subsidiaries of large for-profit companies typically "upstream" the amount of surplus not needed for solvency to the corporate parent, for payment of stockholder dividends or the company's larger strategic purposes. The funds can also be used to increase market share by subsidizing rates (particularly when a health plan seeks to expand its service area), make needed investments in infrastructure and technology, and finance acquisitions.

As shown in Table 15, most health plans maintained healthy levels of surplus, well in excess of NAIC minimums. For HMOs, Independent Health and ConnectiCare (the HIP subsidiary) reported surplus at the high end of the RBC scale, with 1,335 percent and 1,055 percent respectively. Overall, HMO surpluses averaged 498 percent. GHI's HMO, with 202 percent, was at the low end. For Article 43s, with an average of 492 percent, HIP (684 percent) and Excellus (664 percent) led the rankings; CDPHP trailed the pack at just 73 percent. For Article 42s, United reported surplus levels of 4,634 percent of the RBC level — nearly seven times the average of 661 percent — with Oxford following at 1,430 percent.

Spending

Table 16 shows health plan revenues for HMOs and Article 43s on a per member per month (PMPM) basis; Table 17 shows how much health plans spent PMPM on medical claims, and the resulting MLRs, the ratios of claims payments to premiums, also known as medical cost ratios. These data were not available for Article 42s.

Medical Loss Ratios. As fractions representing the percentage of collected premiums that health plans pay out for claims, MLRs are important figures for a number of reasons. Health plans — and equity analysts — use MLRs as a key measure of a plan's performance. Health plans try to keep MLRs as low as possible given state minimums. Higher MLRs mean lower profits, and that a health plan's previous-year forecast of medical expenditures was "off" for some reason. State regulators use MLRs to keep an eye on health plan solvency; a ratio above 100 percent means that a plan is paying out more in claims expenses than it collects in premiums. Regulators also check to make sure that plans charging file-and-use rates are adhering to minimum standards for benefit payouts.

As shown in Table 17, Atlantis, a company specializing in HDHP/HSAs, posted the lowest 2006 MLR among HMOs, at 64 percent. This means that 36 percent of its collected premium was available for administrative expenses and profits. UnitedHealthcare's HMO posted an MLR of over 107

123 Press release from Governor Edward G. Rendell, Commonwealth of Pennsylvania. February 2005. Governor Rendell announces unprecedented agreement with the "Blues" for commitment to annual community health reinvestment. http://www.state.pa.us/papower/cwp/view.asp?A=11&Q=440492.

124 Lewin Group. June 2005. Considerations for regulating surplus accumulation and community benefit activities of Pennsylvania's Blue Cross and Blue Shield plans. Prepared for the Legislative Budget and Finance Committee, Pennsylvania General Assembly.

Table 15. **End of Year Surplus (Net Worth) for New York Health Plans, 2006**

Article 44 HMOs	**2006 Surplus**	**Surplus per Member**	**Risk Based Capital**	**RBC Control Ratio**
Aetna Health	188,582,522	981.05	26,486,129	712%
AmeriChoice	66,737,042	597.37	8,533,000	782%
Atlantis Health Plan	(1,902,676)	(155.70)	1,232,334	-154%
CDPHP	179,882,607	691.40	29,926,482	601%
Cigna Healthcare	30,350,844	1,126.19	5,223,934	581%
ConnectiCare of New York	5,284,711	146,797.53	501,045	1055%
ElderPlan	53,001,590	3,138.42	8,761,775	605%
Empire HealthChoice HMO	380,497,993	656.01	80,089,794	475%
GHI HMO	14,683,805	263.77	7,280,763	202%
Health Net of New York	58,517,306	358.10	52,649,431	111%
Independent Health Association	278,753,258	1,034.78	20,886,756	1335%
Managed Health Inc.	82,017,993	1,081.72	24,348,329	337%
MDNY Healthcare	(21,891,691)	(864.02)	3,905,299	-561%
MVP Health Care	122,608,695	518.29	31,485,328	389%
Oxford Health Plans	448,790,118	883.37	101,199,796	443%
Preferred Care	163,241,643	801.12	18,932,719	862%
UnitedHealthcare of New York	116,332,392	1,065.82	13,994,910	831%
WellCare of New York	60,941,445	520.00	11,336,043	538%
TOTAL	2,226,429,597	692.62	446,773,867	498%

Article 43 Nonprofit Insurers	**2006 Surplus**	**Surplus per Member**	**Risk Based Capital**	**RBC Control Ratio**
CDPHP Universal Benefits	2,725,558	63.20	3,743,744	73%
Excellus Health Plan	1,132,311,656	730.95	170,602,280	664%
Group Health Inc.	240,819,849	206.49	83,585,874	288%
Health Insurance Plan of Greater NY	924,531,949	968.19	135,212,956	684%
HealthNow New York	462,019,812	1,470.41	72,404,596	638%
Independent Health Benefits	18,458,284	345.13	6,136,678	301%
Preferred Assurance	1,260,503	85.71	301,170	419%
TOTAL	2,782,127,611	679.27	471,987,298	492%

Article 42 Accident and Health Insurers	**2006 Surplus**	**Surplus per Member**	**Risk Based Capital**	**RBC Control Ratio**
Aetna Health Insurance of America	6,387,684	132.89	890,039	718%
Empire HealthChoice Assurance	1,322,972,434	532.75	292,258,146	453%
Health Net Insurance of New York	74,712,845	1,112.31	7,889,011	947%
HIP Insurance Company of New York	21,284,085	254.23	2,323,813	916%
Horizon Healthcare Insurance Company of NY	29,810,662	975.74	7,067,072	422%
MVP Health Insurance	19,425,968	524.12	2,003,326	970%
Oxford Health Insurance	615,216,069	635.26	43,018,617	1430%
PerfectHealth Insurance Company	4,369,114	1,692.14	361,222	1210%
United HealthCare Insurance Company of New York	299,203,032	201.39	6,457,358	4634%
TOTAL	2,393,381,893	459.68	362,268,604	661%

Note: RBC = Risk Based Capital Ratio. A ratio of 200 percent is usually required; lower than that means that the state regulator may take inspection and enforcement actions.

Source: Author's analysis of health plan annual statements, Assets, Liabilities and Capital; Five-Year Historical Summary.

percent for that same year, unusual for any health plan let alone an aggressive for-profit one. Based on MLRs in the 80 to 82 percent range for the three previous years, however, that appears to have been an anomaly. Overall, HMOs averaged MLRs of 82.9 percent. Even with the unusual result for United, for-profit HMOs' loss ratios averaged about 5 percentage points less than nonprofit HMOs' in 2006.

Nonprofit Article 43s, overall, had average MLRs about 5 percent higher than those of HMOs. In this group, GHI had the highest MLR, at 90.1 percent, and HIP the lowest, at 82.3 percent. Nonprofit health plans and consumer advocates alike point to the higher MLRs these plans report as evidence that consumers and health care providers get a better deal from them than from for-profit organizations.

Taxes. Health plan premiums and income for fully insured coverage are taxed in different ways, depending on the type of plan providing the coverage. For-profit HMOs pay a type of corporate income tax akin to taxes in other businesses, and Article 42 insurers pay taxes on their premiums. Changes adopted in the

Table 16. **Commercial Health Plan Revenues Per Member Per Month, 2003-2006**

Article 44 HMOs	**2003**	**2004**	**2005**	**2006**	**Change 2006/2005**
Aetna Health	258.83	286.88	314.48	341.49	8.6%
Atlantis Health Plan	232.44	211.09	248.63	266.51	7.2%
CDPHP	208.49	307.29	249.86	259.65	3.9%
Cigna Healthcare	245.25	301.10	317.80	327.79	3.1%
ConnectiCare of New York	412.25	487.08	432.69	372.58	-13.9%
Empire HealthChoice HMO	233.37	251.38	296.50	293.02	-1.2%
GHI HMO	219.03	234.10	259.37	281.07	8.4%
Health Net of New York	168.37	184.97	202.27	215.26	6.4%
Independent Health Association	179.99	196.36	219.17	234.60	7.0%
Managed Health Inc.	255.54	274.25	270.28	229.70	-15.0%
MDNY Healthcare	244.81	270.77	296.88	296.77	0.0%
MVP Health Care	224.45	250.09	275.15	301.17	9.5%
Oxford Health Plans	258.00	285.78	312.87	344.96	10.3%
Preferred Care	188.76	205.73	205.32	218.28	6.3%
UnitedHealthcare of New York	269.87	326.83	437.42	404.60	-7.5%
Subtotal	230.47	258.23	276.12	287.37	4.1%
Article 43 Nonprofit Insurers	**2003**	**2004**	**2005**	**2006**	**Change 2006/2005**
CDPHP Universal Benefits	138.74	218.22	225.10	267.99	19.1%
Excellus Health Plan	193.05	208.46	235.38	234.56	-0.3%
Group Health Inc.	150.32	158.32	149.97	150.35	0.3%
Health Insurance Plan of Greater New York	217.50	258.30	256.97	279.90	8.9%
HealthNow New York	223.52	238.74	251.85	270.17	7.3%
Independent Health Benefits	17.81	77.64	193.73	211.61	9.2%
Preferred Assurance	6.30	11.42	20.25	24.54	21.2%
Subtotal	186.89	203.98	205.43	220.86	7.5%

Source: Author's analysis of HMO annual statements, New York supplement, and NAIC annual statements, Analysis of Operations by Lines of Business.

Table 17. **HMO and Article 43 Medical Expenses Per Member Per Month, and Medical Loss Ratios, 2003-2006**

MEDICAL EXPENSES

Article 44 HMOs	**2003**	**2004**	**2005**	**2006**
Aetna Health	192.73	229.55	209.42	272.20
Atlantis Health Plan	129.40	128.66	153.29	170.91
CDPHP	192.51	211.40	220.80	222.56
Cigna Healthcare	228.03	267.09	234.97	307.88
ConnectiCare of New York	220.25	382.21		240.28
Empire HealthChoice HMO	189.17	207.30	248.65	242.94
GHI HMO	271.74	196.13	240.86	259.57
Health Net of New York	142.03	162.75	160.23	174.25
Independent Health Association	162.01	173.07	187.23	212.77
Managed Health Inc.	211.30	230.92	246.22	195.83
MDNY Healthcare	210.77	233.60	258.84	269.46
MVP Health Care	194.29	218.62	239.07	267.82
Oxford Health Plans	200.57	229.38	242.04	265.33
Preferred Care	159.26	170.73	170.92	185.32
UnitedHealthcare of New York	238.81	235.36	432.16	436.16
Subtotal	189.37	209.92	223.01	238.16

Article 43 Nonprofit Insurers	**2003**	**2004**	**2005**	**2006**
CDPHP Universal Benefits	123.12	194.82	223.09	240.78
Excellus Health Plan	174.13	186.85	197.78	206.21
Group Health Inc.	134.47	140.08	140.54	135.43
Health Insurance Plan of Greater New York	169.85	187.99	204.27	230.27
HealthNow New York	192.04	216.69	221.49	238.19
Independent Health Benefits	12.52	65.62	170.81	186.69
Preferred Assurance	0.27	5.16	11.87	20.60
Subtotal		175.66	178.89	192.60

Continued on following page

FY 2009-2010 budget for New York State, however, will tax for-profit HMOs like Article 42s, and increase taxes by over $100 million. Nonprofit HMOs and Article 43s are exempt from state premium and income taxes and local property taxes. Most Article 43 insurers, however, pay federal income tax on their earnings.

In 2006, HMOs paid $287.3 million in income taxes, Article 43s paid $84.8 million (largely federal), Article 42s paid $220.2 million, and for-profit prepaid health services plans paid $9.5 million on their public program business.

Surcharges and Assessments. Another health plan expense is the variety of surcharges and assessments plans must pay. All domestic (New York-based) insurers pay assessments pursuant to Section 332 of the Insurance Law to support the annual State Insurance Department operating budget, which includes suballocations to other state agencies for their expenses, and funding for other

Table 17. **HMO and Article 43 Medical Expenses Per Member Per Month, and Medical Loss Ratios, 2003-2006** (cont.)

MEDICAL LOSS RATIOS

Article 44 HMOs	**2003**	**2004**	**2005**	**2006**
Aetna Health	74.5%	80.0%	66.6%	79.7%
Atlantis Health Plan	55.7%	60.9%	61.7%	64.1%
CDPHP	92.3%	68.8%	88.4%	85.7%
Cigna Healthcare	93.0%	88.7%	73.9%	93.9%
ConnectiCare of New York	53.4%	78.5%	0.0%	64.5%
Empire HealthChoice HMO	81.1%	82.5%	83.9%	82.9%
GHI HMO	124.1%	83.8%	92.9%	92.4%
Health Net of New York	84.4%	88.0%	79.2%	80.9%
Independent Health Association	90.0%	88.1%	85.4%	90.7%
Managed Health Inc.	82.7%	84.2%	91.1%	85.3%
MDNY Healthcare	86.1%	86.3%	87.2%	90.8%
MVP Health Care	86.6%	87.4%	86.9%	88.9%
Oxford Health Plans	77.7%	80.3%	77.4%	76.9%
Preferred Care	84.4%	83.0%	83.2%	84.9%
UnitedHealthcare of New York	88.5%	72.0%	98.8%	107.8%
Subtotal	82.2%	81.3%	80.8%	82.9%

Article 43 Nonprofit Insurers	**2003**	**2004**	**2005**	**2006**
CDPHP Universal Benefits	88.7%	89.3%	99.1%	89.8%
Excellus Health Plan	90.2%	89.6%	84.0%	87.9%
Group Health Inc.	89.5%	88.5%	93.7%	90.1%
Health Insurance Plan of Greater New York	78.1%	72.8%	79.5%	82.3%
HealthNow New York	85.9%	90.8%	87.9%	88.2%
Independent Health Benefits	70.3%	84.5%	88.2%	88.2%
Preferred Assurance	4.3%	45.2%	58.6%	83.9%
Subtotal		86.1%	87.1%	87.2%

Source: Author's analysis of health plan annual statements, Analysis of Operations by Line of Business.

programs. Insurers headquartered in other states are exempt from the assessment, which is calculated proportionally based on each domestic company's total premiums. These Department assessments have grown exponentially in recent years, as spending by other agencies and for other programs has been loaded into the Department's budget to free up cash elsewhere. Since New York is home to comparatively few domestic property and casualty companies insuring cars, homes, workers compensation, etc., the assessment falls heavily on Article 43s, HMOs, and Article 42s based in New York selling life and health insurance. In the recently adopted FY 2009-2010 budget, the assessment grew to over $455 million.

Avoiding premium taxes is a major price advantage for businesses that self-insure their health benefit plans, but New York imposes two major surcharges on both fully insured and self-funded health coverage, under the HCRA law enacted in 1996 and subsequent amendments. The assessments are, to some

degree, reflected in the premiums individuals and businesses pay.

The HCRA surcharge, a kind of sales tax on certain inpatient and outpatient services, ranges from 6.54 percent for government programs to, in rare cases, 26.26 percent for employer groups, although the rate for most commercial health insurance is 8.95 percent. The surcharge is paid by health plans, self-funded employer groups, and uninsured "self-pay" patients. The resulting revenue supports a number of programs funded through the HCRA Indigent Care/Health Care Initiatives Pool, and provides some general budget relief. For state fiscal year 2008-2009, payers will be assessed an estimated $2.091 billion.[125] An increase in the surcharge adopted in the FY 2009-2010 budget will raise an additional $126 million.

In addition to the surcharges, annual HCRA "covered lives" assessments imposed by HCRA support graduate medical education in New York. Under the program, each fully insured and self-funded plan "elects" to pay a fixed dollar amount each year, for each person covered under an insurance policy or benefit plan, or a surcharge based on use of services. The assessment or surcharge is developed and applied on a regional basis, according to the number of teaching hospitals in each of eight regions. The New York City region has the highest assessment rate, at $613.56 for family coverage annually; Central New York has the lowest, with $25.11 for family coverage. An increase in the covered lives assessments included in the FY 2008-2009 budget will increase annual revenues to $1.16 billion.

Steady increases over the years in both the surcharges and covered lives assessment have drawn the ire of health plans and employer groups, who question the wisdom of increasing the cost of health insurance at a time when coverage is already declining due to those costs. It's difficult to say just how much the two components increase premiums, though. Of the two, the covered lives assessment seems closest to a straight pass-through to insurance buyers — over $1 billion a year. One administrator of a large self-funded plan in New York City says the covered lives assessment essentially amounts to an extra month's family premium: "We're paying thirteen months of premiums for twelve months of coverage."

The impact of the surcharge is more difficult to assess. A forerunner of it was in place under the health care financing system that preceded HCRA in New York. Because it has been part of the system for so long, the surcharge is a familiar "fixed cost" that health plans and providers work around when negotiating rates. Still, the New York State Conference of Blue Cross Blue Shield Plans estimates that the HCRA surcharge and covered lives assessment together increase premiums for standard group policies by 3 percent in Central New York, 5 percent in Western New York, and 7 percent in the New York City area.[126] A spokesperson for the Conference claimed that the FY 2009-2010 budget tacks on another $675 million to New Yorkers who "already pay more than $3.7 billion in state health taxes."[127] The head of the leading HMO trade association called the increases "bad for the health of New York," and added that the assessments, taxes, and surcharges "punish those who 'do the right thing' by providing health insurance to their employees, while those employers that could afford it but don't provide health benefits to their workers get away unharmed."[128]

New York has a reputation as a high-

125 New York State Division of the Budget. Updated HCRA Financial Plan.

126 Klein D [chief executive officer, Excellus Blue Cross Blue Shield]. September 5, 2007. Promoting private coverage solutions to address the uninsured. Prepared remarks before the New York State Departments of Health and Insurance.

127 Fasser DK [NYSCOP spokeswoman]. March 30, 2009. Statement regarding the 2009-10 New York budget.

128 Macielak P [president and CEO, New York Health Plan Association]. March 30, 2009.

Table 18. **Capitation Payments by New York Health Plans, 2006**

Article 44 HMOs	**Capitation Payment**	**Other Payments**	**Total Medical Payment**	**% Paid Through Capitation**
Aetna Health	53,312,303	713,089,630	766,401,933	7.0%
AmeriChoice	9,524,978	193,534,709	203,059,687	4.7%
Atlantis Health Plan		16,474,890	16,474,890	0.0%
CDPHP	29,438,536	685,352,592	714,791,128	4.1%
CignaHealthcare	10,170,444	109,514,192	119,684,636	8.5%
ConnectiCare of New York	456	64,731	65,187	0.7%
ElderPlan	11,961,157	192,862,396	204,823,553	5.8%
Empire HealthChoice HMO	119,335,316	1,968,556,738	2,087,892,054	5.7%
GHI HMO	6,765,091	166,923,496	173,688,587	3.9%
Health Net of New York	133,017,306	435,981,863	568,999,169	23.4%
Independent Health Association	850,634,321	18,324,207	868,958,528	97.9%
Managed Health Inc.	8,617,561	406,839,978	415,457,539	2.1%
MDNY Healthcare	1,159,556	82,269,406	83,428,962	1.4%
MVP Health Care	14,626,896	830,720,169	845,347,065	1.7%
Oxford Health Plans	160,460,536	1,965,790,734	2,126,251,270	7.5%
Preferred Care	705,700,810	77,846,907	783,547,717	90.1%
UnitedHealthcare of New York	11,617,855	351,018,205	362,636,060	3.2%
WellCare of New York	24,526,402	178,856,593	203,382,995	12.1%
Subtotal	2,150,869,524	8,394,021,436	10,544,890,960	20.4%
Article 43 Nonprofit Insurers	**Capitation Payment**	**Other Payments**	**Total Medical Payment**	**% Paid Through Capitation**
CDPHP Universal Benefits	3,591,820	112,162,571	115,754,391	3.1%
Excellus Health Plan	578,437,689	3,712,688,492	4,291,126,181	13.5%
Group Health Inc.	1,788,118	2,106,893,277	2,108,681,395	0.1%
Health Insurance Plan of Greater New York	1,199,565,918	2,151,176,870	3,350,742,788	35.8%
HealthNow New York	28,360,912	1,850,764,432	1,879,125,344	1.5%
Independent Health Benefits		115,182,912	115,182,912	0.0%
Preferred Assurance		3,106,839	3,106,839	0.0%
Subtotal	1,811,744,457	10,051,975,393	11,863,719,850	15.3%
Article 42 Accident and Health Insurers	**Capitation Payment**	**Other Payments**	**Total Medical Payment**	**% Paid Through Capitation**
Aetna Health Insurance of America		12,867,869	12,867,869	0.0%
Empire HealthChoice Assurance	34,419,407	4,560,907,085	4,595,326,492	0.7%
Health Net Insurance of New York	15,930,172	279,674,278	295,604,450	5.4%
HIP Insurance Company of New York		37,879,948	37,879,948	0.0%
Horizon Healthcare Insurance Company	486,248	170,582,770	171,069,018	0.3%
Humana Insurance Company of New York		107,768,447	107,768,447	0.0%
MVP Health Insurance		41,412,678	41,412,678	0.0%
Oxford Health Insurance	75,983,267	2,517,618,724	2,593,601,991	2.9%
PerfectHealth Insurance Company		1,310,735	1,310,735	0.0%
United HealthCare Insurance Co. of NY		2,806,886,205	2,806,886,205	0.0%
Subtotal	126,819,094	10,536,908,739	10,663,727,833	1.2%

Source: Author's analysis of annual health plan statements, Summary of Transactions with Providers.

premium state, and it is somewhat deserved. According to the Agency for Healthcare Research and Quality, the average total premium for employees at private-sector establishments in 2008 was $4,386, with Hawaii lowest among states at $3,831 annually. New York was the fourteenth highest, at $4,638; that makes the difference between high-cost New York and low-cost Hawaii about $66 per month.[129] What is not known is how much of the difference in premiums between the two states is due to New York's surcharges and assessments.

129 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2008. *2008 Medical Expenditure Panel Survey—insurance component.* Table II.C.1.

Part III: The Self-Funded Market

Many New Yorkers receive health benefits through "self-insured" or "self-funded" arrangements. Under these arrangements, no insurance policy is purchased to provide the benefits; instead, companies or groups of companies, sometimes in tandem with labor organizations, determine the benefits to be included, set aside funds in special accounts, and hire a firm to administer the plan by arranging provider networks, handling enrollment of workers and dependents, and paying claims.

Self-funded arrangements managed by health plans are known as Administrative Services Only (ASO) contracts or Administrative Services Contracts (ASC). While some market participants use the terms interchangeably, others say the difference is that under an ASC, the health plan takes on additional risk because it advances its own funds for the payment of claims and is later reimbursed by the employer group. Self-funded plans may also be run by third-party administrators (TPAs), independent benefit administrators operating without an insurance license. TPAs are not specifically licensed entities in New York, but firms operating as TPAs typically have some form of licensure as an insurance producer, claims adjuster, or utilization review agent.

Even if a health plan is involved, self-funded arrangements are exempt from insurance regulation, since there is no insurance policy, premium payment, or transfer of risk. Some state laws and regulations apply to self-funded plans, but they are mainly governed by federal rules and regulatory agencies, chiefly the U.S. Department of Labor and the IRS, which requires filing of an annual "Form 5500," containing detailed financial information on the arrangements.

Information on enrollment in self-funded plans is difficult to obtain, but some reasonable estimates can be made. The Agency for Healthcare Research and Quality (AHRQ) estimates that 40.5 percent of New Yorkers were enrolled in self-funded plans in 2005,[130] a significantly lower rate than in neighboring states Pennsylvania (52.6 percent), Connecticut (52.2 percent), and New Jersey (50.1 percent). According to an annual national survey of employer-sponsored coverage,[131] the proportion of workers, nationally, in partially or completely self-funded plans was 55 percent in 2007. The California HealthCare Foundation reports a much lower rate of self-funding there for 2006, just 31 percent.[132]

Many factors, including the extent of HMO penetration and the distribution of businesses by size, influence rates of self-funding. Some market observers speculate that New York's rate of self-funding might be lower than average because of the partnership structure of many financial services

130 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005. *2005 Medical Expenditure Panel Survey—insurance component.* Table 11.B.2.b(1).

131 Claxton G, B DiJulio, B Finder, M Jarlenski, M McHugh, S Hawkins, J Pickreign, H Whitmore, and J Gabel. 2009. *Employer health benefits 2008 annual survey.* Menlo Park, CA, and Chicago: The Kaiser Family Foundation and Health Research & Educational Trust.

132 California Health Care Foundation and The Center for Studying Health System Change. November 2006. *The California employer health benefits survey.* http://www.chcf.org/documents/insurance/EmployerBenefitsSurvey06.pdf.

and law firms, and IRS rules that distinguish between payments from insurance companies and from self-funded arrangements.

Applying the AHRQ 40.5 percent rate to estimates of employer-sponsored coverage for combined years 2005-2006[133] yields estimated enrollment of 4,365,000 New Yorkers in self-funded plans. A review of data collected by the state Department of Health to administer HCRA-mandated assessments on fully insured and self-funded health plans suggests this estimate is reasonable.[134]

ASO/ASC Arrangements

Most health plans that administer self-funded benefit arrangements have dedicated units within their companies that specialize in that business. National health plans operating in New York — Empire/Wellpoint, Aetna, Cigna, and United HealthGroup, for example — have a natural market advantage because they can more easily serve the needs of multi-state employers through national networks. Blue Cross plans nationally "share" each other's networks, and market the BlueCard program developed by the Blue Cross Blue Shield Association, which allows enrollees traveling outside their service areas to more easily access participating providers when medical care is needed.

Data by health plan on ASO membership is a mix of informal reports and regulatory filings, with a greater focus in the latter on revenue than membership. MVP HealthCare officials, for example, estimated about 50,000 members enrolled through ASO business in 2006, and Buffalo-based Blue Cross plan HealthNow about 200,000. Annual statements to insurance regulators vary according to the reporting entity and state of domicile. In 2006, Empire reported payment of more than $5 billion in claims, with net gains of over $134 million through its ASO activities.[135] Excellus Blue Cross Blue Shield reported net gains of $4.3 million from $34 million in revenues from its ASO operations

Even when it does not produce significant profits — as with HIP's and HealthNow's 2006 profits of less than $100,000 — ASO business is important because it can bring in millions of dollars in revenue to support the administrative infrastructure in place for fully insured products. Reflecting the importance of self-funded businesses, a number of upstate health plans, including MVP Healthcare, CDPHP, HealthNow, Excellus, and Independent Health, have added third-party administrators in recent years to complement their ASO operations. Some for-profit health plans — such as Aetna, with over 16 million enrollees nationwide, two-thirds of them in self-funded arrangements — place their self-funded and fully insured business in one category, simply called "medical members." Some plans call ASO revenues "premium equivalents" and lump total ASO revenue and fully insured premiums together.

Retaining employer groups that might leave the fold for another insurer or third-party administrator is the goal of the health plans' self-funded operations, but the business is bittersweet — particularly in upstate markets such as the Rochester and Buffalo areas, with a long tradition of fully insured, community-rated business. And as an upstate health plan administrator noted, "earning 3 percent on a $350 per month insurance premium is one

133 Holahan D, A Cook, and A. Williams. 2008. *Health insurance coverage in New York, 2005-2006.* New York: United Hospital Fund.

134 The Department of Health collects data from self-insured plans that "elect" to pay covered lives surcharges for their employees. Based on data filed for 2007, self-insured plans reported average monthly enrollment of 1,290,000 individual coverage arrangements and 1,335,000 family coverage arrangements. Multiplying the family coverage totals by factors of 2.0 to 2.3 in order to reflect family size produces a range of 3.96 million to 4.4 million individuals covered by self-insured plans.

135 Empire HealthChoice Assurance Inc. 2006 Annual Statement.

thing, but 3 percent on a $57 per member per month ASO charge is another." Reflecting health plans' need to hold on to membership, fully insured or not, the website homepage of the Lifetime HealthCare Companies, the parent of the Excellus Blue Cross companies, is just four clicks away from a page on the advantages of self-funding (via their subsidiary RIMSCO).

The Role of Third-Party Administrators

In the self-funded market, TPAs are regarded as the leaner, more flexible outfits that can more easily tailor benefit plans to individual clients with particular needs. TPAs often provide a full range of services, including employee enrollment, claims payment, COBRA administration, wellness and care management programs, utilization review, and setting up cafeteria plans, tax-favored accounts that employees can use to pay child care or medical expenses. Without benefit of the in-house provider network that health plans have, TPAs sometimes arrange their own networks, or contract with "rent-a-network" companies to do so. Network leasing firms, often called PPOs, are another example of unlicensed entities that are an integral part of self-funded benefit plans. These companies (MagnaCare, Multi-Plan, and PHCS, for example), take on no risk, but assemble networks of health care providers, negotiate discounts, and then lease the networks to self-funded plans.

Syracuse-based POMCO Group is one of New York's most successful homegrown TPAs, with over 340 employees in three divisions and seven offices throughout the state. Like many TPAs, it was started by an insurance agent. It grew from revenues of $36,000 in 1978 to $41 million in 2008, managing "premium equivalents" of $1 billion and earning a ranking in the top 10 percent of independent TPAs nationally. The springboard for this success was POMCO's enrollment of Westchester County public employees very early on; further growth came with enrollment among school districts and hospitals.

Building on that strength with schools, in January 2009 POMCO announced that it had begun administering medical benefits for the 20,300 covered lives of a consortium of twenty-three school districts in Westchester County, replacing long-time administrator Empire BlueCross BlueShield. POMCO officials report that the company administers benefits for twenty-eight school districts and twenty-two municipalities statewide, representing over 170,000 covered lives.

In Westchester, POMCO competes with Empire, and in Syracuse with Excellus and UnitedHealthcare. Still, it considers itself "the Central New York leader in self-funding," with contracts to administer benefits for GM, Chrysler, Lockheed-Martin, and Carrier. POMCO executives believe it's the ability to save their customers money (they tout their customers' average increase of 7.8 percent, compared to average fully insured premium increases of 11 percent) and tailor benefit designs for individual customers that sets it apart from their larger insurance company competitors. Unlike the insurers, which can easily pull fully insured product designs off the shelf and market them to self-funded clients, POMCO starts from scratch. "We don't have a 'shelf' like our larger, insurance company competitors," said one official.

Building a Rate

Rates for self-funded plans are developed on a per member per month basis through negotiations with the administrator, and with the assistance of actuarial and benefit design consultants. Each cost component is developed and assigned a monthly per-employee value. Self-funded plans typically pay a fee for "leasing a network" in

which members will get their care, thereby realizing the benefit of discounted provider rates. The cost of premiums for stop-loss coverage, if any (see below), is factored in, as are the cost of the administrator's services (which will include a profit margin) and any relevant taxes and fees (such as HCRA surcharges).

The administrator's PMPM fee is based on the laundry list of services that it delivers, but may be less than a quarter of the premium the employer group would pay for a fully insured policy, since the group is also depositing money with the administrator, each month, to pay for claims. Some employer groups might fully insure the hospital portion of benefits while self-funding other benefits, and many larger employer groups and collectively bargained plans offer employees both fully insured and self-funded options.

Stop-Loss Coverage

When self-funded arrangements began to emerge in the 1960s, only the largest firms — typically multistate companies or multi-employer collective bargaining groups — took the plunge. In New York in 2006, almost 75 percent of employees at companies with 1,000 or more employees were enrolled in self-funded plans, but only 14 percent of employees at firms with between 100 and 999 employees were covered under these arrangements.[136]

Self-funding for smaller businesses is comparatively rare. While POMCO markets a self-funded product to employer groups of over fifty, for example — very carefully underwritten — most market participants agree that self-funding for groups of less than 200 workers is risky. With no insurance policy in place, unexpected claims costs can overwhelm a business without the capital to ride out a bad stretch. The development of a new stand-alone insurance product, stop-loss coverage, in the early 1980s made self-funding an option for medium-sized employers.

Stop-loss coverage is modeled on the "pooling charge" option available under experience-rated contracts. Under this feature, employer groups pay an added PMPM fee in exchange for having incidences of high claims experience wiped clean from the slate. The charge is based on the level of claims, or "attachment point," above which losses are forgiven. Similarly, stop-loss policies can protect an employer group against the risk of extraordinary claims from a specific individual ("specific" or "spec") covered under the plan and the total claims of the group ("aggregate" or "ag"). The premium varies according to the risk profile of the employer group, which is carefully underwritten by the stop-loss carrier, and the attachment point the employer selects. Smaller employers will purchase both spec and ag coverage; medium-sized employers typically purchase only ag coverage; and larger employers self-fund the entire risk of a "bad year." Underwriting spec coverage is difficult and risky; one stop-loss carrier CEO compared the practice to "picking which house is going to burn down."

In an ASO arrangement, the health plan administrator may sell the employer group a stop-loss policy, along with its administrative services and charges, or it may be purchased from a stop-loss carrier, particularly if a broker or consultant is advising the employer group. When a TPA is involved, the stop-loss policy is purchased from a stop-loss carrier. Commissions typically fall in the 10 to 15 percent range. Prominent stop-loss carriers doing business in New York include Highmark, a subsidiary of a Pennsylvania Blue Cross plan, Mutual of Omaha, SunLife, HCC Holdings, and AIG.

In New York, stop-loss is considered a type of accident and health insurance coverage, and policy forms and rates are overseen by the State Insurance Department. In order to

136 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006. *2006 Medical Expenditure Panel Survey—insurance component.* Table 11.B.2.b(1).

differentiate between fully funded and self-funded plans with stop-loss coverage, the SID informally requires attachment points of no less than $20,000 ($25,000 for new benefit plans). Prior to enactment of the stop-loss insurance law in 1999,[137] a 1985 "Actuarial Information Letter" governed stop-loss policies in New York. Portions of the letter were ruled invalid by the courts in the famous Travelers v. Cuomo ERISA case.

A fairly recent trend in the industry is "lasers," special riders to stop-loss contracts that "laser out" — exclude coverage for — named higher-risk individuals or dependents otherwise covered under the policy. These lasers are sometimes presented as take-it-or-leave-it propositions and other times as options affecting the contract price.

Benefits of Self-Funding

While both freedom from state-mandated health benefits and "bargaining power" are often cited as the reasons employer groups self-fund, both groups and plan administrators put those reasons far down on the list.

According to the 2007 Kaiser/HRET annual survey, from 1999 to 2007 premiums for fully insured plans increased an average of 1.5 percent more than for self-funded plans, with the biggest difference (3 percent) in 2003 and the smallest (0.2 percent) in 2007. While many observers point to the savings self-funded plans achieve, due to exemption from state-mandated benefits that apply to fully funded plans, plan administrators and employer groups noted that benefits for self-funded and fully insured plans don't actually differ that much. New York's limited infertility services benefit was cited as one difference, as were required mental health and substance abuse services benefits. Administrators for multi-state employers also noted that minor differences in mandated benefits from state to state have to be accommodated.

A 2004 report[138] comparing Maryland's mandates for fully insured plans with benefits provided for self-funded groups concluded that the self-funded arrangements voluntarily covered 90 percent of the cost of state-mandated services. The biggest differences were in two areas: mental health/substance abuse and in vitro fertilization services. Since the study estimates a marginal cost increase for all mandates (the extra premium costs that fully insured employer groups incur as the result of the mandates) of just 1.6 percent of premium, the savings these self-funded Maryland employers gained from the absence of state-mandated benefits in their plans was minimal.

As for bargaining power, self-funded groups pay a fee to harness a health plan or TPA's bargaining power with providers. If the employer group is of such a size that it enhances the health plan's bargaining power with providers by enabling them to demand a greater volume discount, the employer group might receive a discount that recognizes that benefit. Some "marquee name" employer groups will receive an additional discount if their enrollment helps the administrator market its services with other clients. But the common perception of the premium impact of "bargaining power" may be over-valued. While differences in benefits and cost-sharing between small and large employers affect premiums, 2008 average single premiums for employers with 50 or fewer workers in New York were only about $450 more than for employers with 1,000 or more employees.[139]

Instead, the more reliable source of savings in self-funded arrangements is the ability they

137 Chapter 618 of the Laws of 1999, NYIL Section 4237(a).

138 Mercer Human Resource Consulting, for the Maryland Health Care Commission. January 15, 2004. *Study of mandated health insurance services: A comparative evaluation.*

139 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2008. *2008 Medical Expenditure Panel Survey—insurance component.* Table 11.C.1.

give large employers to control their cash flow and earn interest that would otherwise belong to a health plan, and avoid costs such as premium taxes and the "risk premium," the profit that health plans tack on to fully insured contracts for large employer groups.

IBM

When asked why IBM self-funds its employee benefit plan, Craig Weber, MD, MPH, IBM's director of Well-being Services, Americas, replied in a message: "The short answer is we have the capacity (reserves) to take on risk and we pay less because we do not have to pay a risk premium to an insurance company. We pay for losses and administration." IBM self-funds health benefits for the vast majority of its 120,000 U.S. workers, and spends $1.3 billion annually for all its U.S. employees and retirees. The company's size has helped it reduce costs somewhat, Weber says, but "the curve looks the same, it's just a little lower."

Although employees have the option of enrolling in twenty-five HMOs nationally, 80 percent of them join PPO-type plans with comprehensive benefits, administered by five health plans in various regions across the U.S. where employment is concentrated. Over 20,000 New York employees enroll through Schenectady-based MVP HealthCare or Empire BlueCross BlueShield, in three plan options: a basic PPO; a PPO with higher premiums but lower cost sharing; and, at a higher price but with the least cost sharing, an EPO with in-network-only coverage through a large provider network.

Having weathered years of double-digit cost increases despite its size, IBM became a corporate pioneer in terms of its effort to control costs through disease management, wellness initiatives, and benefit designs that provide 100 percent coverage for preventive care. The company was one of the first to carve out disease management from its benefit contract with health plans. Today, Alere is the exclusive provider of a wide array of disease management programs for the self-funded plans, while IBM's own medical team and other vendors administer smoking cessation programs, health risk assessments, physical activity plans, personal health records, nutritional counseling, and special programs for kids. The programs are run outside the structure of the insurance coverage, using a system of employee bonuses and salary enhancements of up to $300 annually based on an employee's participation. Employees "love the programs," Weber says, "especially the part about getting paid to do it."

IBM's efforts to measure how the programs were working — and the barriers it faced — led it down the road to becoming a corporate activist on issues such as electronic health records, medical homes, and e-prescribing. Working both locally and nationally, it has collaborated with groups such as the Patient-Centered Primary Care Coalition, Leapfrog Group, Bridges to Excellence, and ERISA Industry Committee.

SEIU Local 32BJ

Turn to page 34 of the pocket-sized 2006 Apartment Building Agreement between Service Employees International Union, Local 32BJ, and the Realty Advisory Board on Labor Relations, and there it is in black and white:

"The Employer shall continue to contribute to the Fund $9,750.64 per year for each employee, payable when and how the Trustees determine, to cover employees and their dependent families with health benefits as agreed by the collective bargaining parties, and under such provisions, rules and regulations as may be determined by the Trustees."

The agreement is just one example of an enduring method by which some New Yorkers get health care: Taft-Hartley trusts, health benefits funds jointly operated by multiple employers and union representatives. With twice the national average of employees

represented by unions in 2007 (26 percent in New York, versus 13 percent nationally),[140] New York labor groups have a long tradition of collectively bargaining for quality health benefits, which are often self-funded through the trusts.

The trusts are named for the 1947 Taft-Hartley Act, legislation that was approved by a Republican Congress over President Truman's veto and that itself was named for the bill's sponsors, Sen. Robert Taft and Rep. Fred A. Hartley. Although widely regarded as an anti-labor rollback of gains under the Roosevelt Administration, the structure it established allowed labor and management to jointly organize plans like 32BJ's, which covers over 170,000 workers, retirees, and dependents in five states. The union's Metro Plan for New York City building workers covers over 50,000 families at a premium rate of $899 a month. Benefits provided are comprehensive, and although members have co-pay and deductible responsibilities they do not contribute to premiums.

The plan is administered by Empire BlueCross BlueShield, although 32BJ handles medical management and prior authorization. Members can get care through a clinic operated by another notable local union, Unite HERE, or through an HMO/POS network maintained by Empire. Barbara Caress, director of strategic planning and policy for the 32BJ Funds (the health benefits fund is one of five), points out that 95 percent of the claims are in-network, and that the fund is working hard to use disease management programs to slow down the costs of care for chronically ill members, who account for two-thirds of plan expenses.

"Our problem is *under*utilization," she said. "Forty percent of our members don't use the benefit."

140 The Henry J. Kaiser Family Foundation. State health facts. http://www.statehealthfacts.org/profileind.jsp?ind=20&cat=1&rgn=34.

Table 19. **Net Income (Underwriting) by Line of Business**

Article 44 HMOs	**Large Group**	**Small Group**	**Individual**	**Healthy NY**	**Medicare**	**Medicaid**	**Family/Child Health Plus**	**TOTAL**
Aetna Health	59,420,381	5,681,469	161,731	(2,058,614)	13,267,629			76,472,596
AmeriChoice			(292,061)		1,101,184	5,285,717	(250,871)	5,843,969
Atlantis Health Plan	(73,218)	(578,173)	44,645	(839,771)				(1,446,517)
CDPHP	14,115,260	3,162,316	66,439	1,104,477	5,517,997	(118,406)	995,072	24,843,155
CignaHealthcare	3,283,455	(454,305)	(3,443,798)	(8,232,929)				(8,847,577)
ConnectiCare of New York		(833,026)	(46,939)					(14,928)
ElderPlan					10,769,331			10,769,331
Empire HealthChoice HMO	42,650,899	55,431,964	6,361,388	5,250,700	61,353,828		3,837,319	174,886,098
GHI HMO	(5,423,660)	(234,316)	(234,508)	(914,988)		(678,570)	1,926,615	(5,482,223)
Health Net of New York	(6,478,803)	18,259,784	419,757	235,342	(3,415,132)			7,984,434
Independent Health Association	1,737,730	269,329	2 ,874,037	3,250,449	34,633,082	(608,173)		42,156,454
Managed Health Inc.		1		(2)	14,417,015	(25)		14,416,989
MDNY Healthcare	(55,299)	(8,308,239)	(132,313)	228,811				(8,267,040)
MVP Health Care	8,266,083	(7,354,359)	(1,108,215)	5,664,081		(1,510,739)	(1,328,666)	2,257,589
Oxford Health Plans	120,851,605	116,356,392	20,847,992	3,562,940	123,424,898			385,043,827
Preferred Care	20,946,773	(904,312)	(193,534)	(87,840)	36,627,706	(1,852,595)		54,536,198
UnitedHealthcare of New York	(2,946,003)	(225,254)	1,315,946	(354,659)	8,601,090	(1,432,861)	5,843,178	10,801,437
WellCare of New York					8,797,493	1,130,244	6,479,881	16,407,618
Subtotal	256,295,203	180,269,271	26,640,567	6,807,997	315,096,121	214,592	17,502,528	802,361,410

Article 43 Nonprofit Insurers	**Large Group**	**Small Group**	**Individual**	**TOTAL**
CDPHP Universal Benefits	(5,058,454)	3,684,578		(1,373,876)
Excellus Health Plan	82,678,942	25,855,226	27,322,640	135,856,808
Group Health Inc.	10,578,439	4,778,636	872,582	16,229,657
Health Insurance Plan of Greater New York	149,443,882		9,113,682	158,557,564
HealthNow New York	41,652,475	(10,201,133)	40,420,537	71,871,879
Independent Health Benefits	1,619,773	1,543,700	(490,662)	2,672,811
Preferred Assurance	302,239	(316,582)		(14,343)
Subtotal	281,217,296	25,344,425	77,238,779	383,800,500

Table 19. **Net Income (Underwriting) by Line of Business** (cont.)

Article 42 Accident and Health Insurers	**Comprehensive**	**Med Supp**	**Fed Employees**	**Medicare**	**Other Health**	**TOTAL**
Aetna Health Insurance of America	453,616	(24,401)				429,215
Empire HealthChoice Assurance*	157,102,177	18,202,860	2,078,436	374,942	107,643,842	289,204,018
Health Net Insurance of New York	13,264,807				3,083,579	16,348,386
HIP Insurance Company of New York	2,296,529			(582,859)		1,713,670
Horizon Healthcare Insurance Company of New York	(30,841,536)					(29,604,481)
Humana Insurance Company of New York					(1,599,202)	(1,599,202)
MVP Health Insurance	1,304,464					1,304,464
Oxford Health Insurance	205,298,485					205,298,485
United HealthCare Insurance Company of New York	(13,961,322)	19,36 ,146		3,591,164	7,701,865	26,345,285
Subtotal	334,917,220	37,542,605	2,078,436	3,383,247	116,830,084	509,439,840

Prepaid Health Services Plans	**Medicaid**	**Child Health Plus**	**Family Health Plus**	**TOTAL**
Affinity Health Plan	(2,081,161)	2,129,902	23,087,288	23,136,029
Amerigroup	8,845,011	644,729	748,560	10,238,300
Centercare	(1,288,955)	108,012	(28,162)	(1,209,105)
Community Choice Health Plan	(1,022,680)	(1,044,622)	161,356	(1,905,946)
Community Premier Plus	(9,061,232)	(29,993)	1,637,196	(7,454,029)
HealthFirst PHSP	6,909,034	425,431	3,783,032	11,117,497
HealthPlus	13,397,897		1,781,306	15,179,203
Hudson Health Plan	(161,383)	403,387	254,665	496,669
MetroPlus Health Plan	(6,818,913)	(1,487,619)	1,781,306	(6,525,226)
Neighborhood Health	(11,401,072)	(4,775,387)	3,108,536	(13,067,923)
NewYork-Presbyterian	(4,982,582)	(802,100)	1,246,095	(4,538,587)
NYS Catholic Health Plan (Fidelis Care)	12,451,087	(2,003,538)	7,166,723	17,614,272
Suffolk County	870,765	(395 ,476)	(10,114)	465,175
Total Care (Syracuse Community Health Center)	508,732	(135,537)	519,714	892,909
Univera Community Health	251,626	303,178	2,577,774	3,132,578
Subtotal	6,416,174	(6,659,633)	47,815,275	47,571,816
Average Margin	0.2%	-2.6%	4.7%	1.1%

HMO lines of business*	**Large Group**	**Small Group**	**Individual**	**Healthy NY**	**Medicare**	**Medicaid**	**Family/Child Health Plus**	**TOTAL**
Excellus Health Plan Inc.	12,685,286	1,456,191	(1,277,783)	(5,287,081)	47,009,226	(1,228,206)	11,688,200	65,045,833
Health Insurance Plan of Greater New York	79,811,610	4,119,517	2,200,261	1,893,071	85,598,699	(7,767,689)	(3,963,172)	161,892,297
Community Blue (HealthNow New York)	41,652,475	(10,201,133)	40,420,537					71,871,879
Subtotal	134,149,371	(4,625,425)	41,343,015	(3,394,010)	132,607,925	(8,995,895)	7,725,028	298,810,009

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

Other net income: for Empire Assurance – dental 3,801,761; Horizon NY – dental 1,237,055; UHC Insurance – dental 50,396, vision 1,109,520, stop-loss 8,489,516.

Source: Author's analysis of annual statements for health plans. For HMOs and HMDIs, New York State supplement reports. For Accident & Health companies, NAIC page 7.

Part IV:
New York State Public Insurance Programs

With enrollment of over 2.8 million residents, New York's trio of public programs — Medicaid Managed Care (MMC), Family Health Plus (FHP), and Child Health Plus (CHP) — now exceeds combined enrollment in the Direct Pay and Small Group markets by over one million covered lives. As commercial enrollment declines, some enrollment migrates to public programs.

Cataloguing the buyers, sellers, market rules, products, and benefits in the public markets is infinitely easier than doing that for commercial markets. With the exception of the State Insurance Department's handling of the rate-setting function for CHP and general solvency regulation, the programs are generally administered by the state Department of Health.

Eligibility

Access to each of these programs is income-based (see Figure 6). CHP offers a full-premium buy-in for non-income-eligible families, and employer and labor unions are permitted to purchase group FHP coverage, but it is not yet widely available in the market. While commercial market plans struggle to maintain enrollment in an era of escalating costs, public program participants struggle to identify and sign up eligible residents — and stem disenrollment due to complex recertification rules. Administration of MMC and FHP through local social service districts is cumbersome. While New York has worked tirelessly of late to untie the Gordian knot of enrollment and recertification, the Fund estimates that over 40 percent of New York's uninsured are eligible for public programs.[141]

Enrollment

Producer compensation arrangements are not permitted in public markets, but from the inception of mandatory enrollment of certain categories of Medicaid recipients in 1993, marketing and enrollment have been hot-button issues for health plans, regulators, and advocates. Enrollment is managed through a mix of state-funded community groups, private vendors, and salaried enrollment staff at health plans.

Incentivizing health plan staff through bonus arrangements tied to enrollment is prohibited; HealthFirst PHSP entered into a $35 million settlement with the Attorney General in 2008 for violating the rules.[142] Seeking to offset the "home field advantage" provider-sponsored plans enjoy — the edge they have in enrolling patients they treat — non-provider-sponsored plans deploy enrollment vans, which are ubiquitous on city streets, particularly at street fairs and other community events. State officials have issued a series of regulations limiting the inducements and gifts that are permitted, and capping marketing expenses.

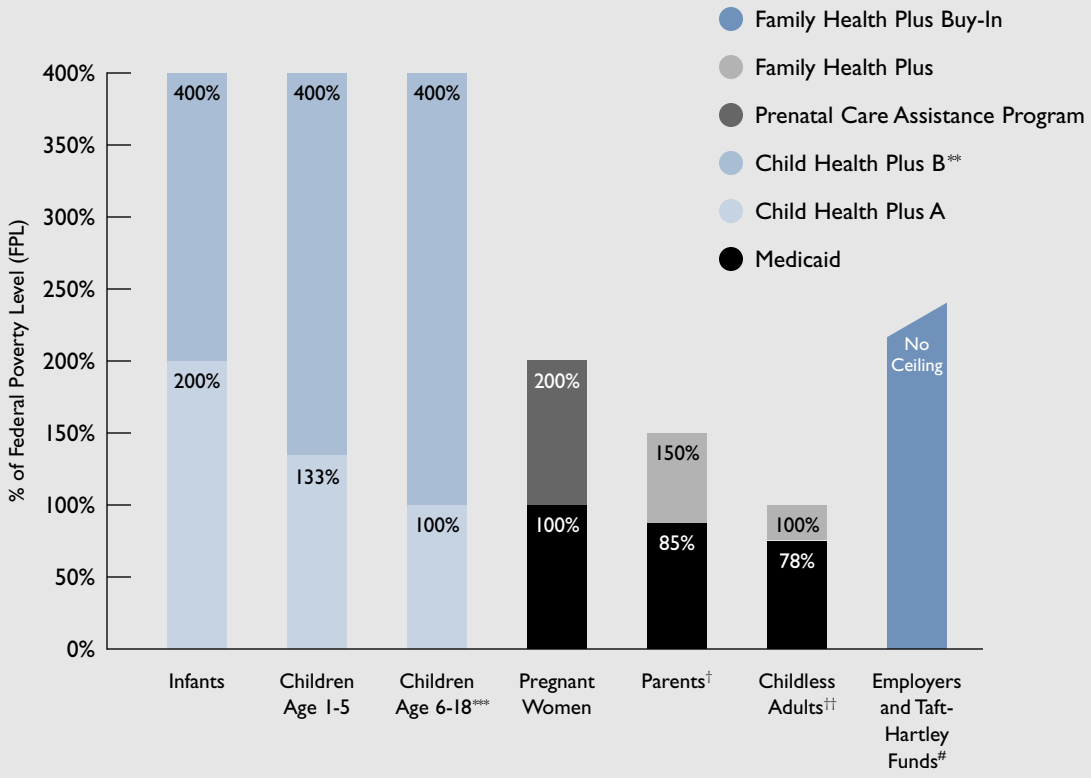
Health Plans

For-profit and nonprofit commercial HMOs, for-profit and nonprofit PHSPs,

141 Holahan D, A Cook, and L Powell. 2008. *New York's eligible but uninsured.* New York: United Hospital Fund.

142 Press release. September 3, 2008. Attorney General Cuomo announces $35 million settlement with managed care provider HealthFirst: Former HealthFirst senior executive indicted.

Figure 6. New York State Eligibility Rules for Medicaid, Child Health Plus, and Family Health Plus, 2009*



Legend:

* Medicaid and Child Health Plus A eligibility are expressed in net income while Child Health Plus B and Family Health Plus eligibility are expressed in gross income, as written in HCRA 2000 and Medicaid law. The 2009 Federal Poverty Level (FPL) is $10,830 for an individual and $18,310 for a family of three.

** Children with gross family income above 160% FPL are charged an income-related premium. Premiums below refer to gross family income: $9/month/child (up to $27) for those between 160-222% FPL, $15/month/child (up to $45) for those between 223-250% FPL; effective July 2009, premiums are $30/month/child (up to $90) for those between 251-300% FPL, $45/month/child (up to $135) for those between 301-350% FPL, and $60/month/child (up to $180) for those between 351-400% FPL. With some exceptions, children in families with income above 250% FPL who lose employer-sponsored coverage are subject to a six-month waiting period.

*** Effective April 2010, all children ages 1-18 will be eligible for Medicaid up to 133% FPL (net income).

† "Parent" is defined as a parent of a child under 21 years who lives in the household. Medicaid eligibility includes disabled adults and 19- and 20-year-olds up to 85% FPL. FHP eligibility includes 19- and 20-year-olds living with their parents up to 150% FPL.

†† "Childless adult" is defined as a non-disabled adult aged 21 years and over who does not have a child living in the household. FHP eligibility includes 19- and 20-year-olds not living with their parents up to 100% FPL. Effective April 2010, all 19- and 20-year-olds will be eligible for Medicaid up to 100% FPL (gross income) and for FHP up to 160% FPL (gross income). Childless couples are eligible for Medicaid up to 73% FPL, while single adults (household of one) are eligible for Medicaid up to 78% FPL.

Employers and Taft-Hartley Funds (THF) may buy in to FHP. Employers/THF must contribute at least 70% of the premium and employees will pay the balance (the State will pay the employee's share for MA/FHP/CHP eligibles). If an employer/THF does not currently offer coverage or is in jeopardy of discontinuing coverage (as determined by the Commissioner), the State may subsidize the employer/THF share of the premium for MA/FHP/CHP eligibles (subject to federal approval and funds appropriated).

Note:

Low-income, uninsured women who are diagnosed with breast or cervical cancer through screenings in New York's Healthy Women Partnerships program are eligible for Medicaid coverage. Women must have income levels below 250% FPL to qualify for the screenings. Females and males of childbearing age with income up to 200% FPL are eligible for Medicaid Family Planning Services. As of July 2003, disabled workers aged 16-64 with net income of up to 250% FPL and non-exempt resources up to $10,000 are eligible for Medicaid coverage through the Medicaid Buy-In for Working People with Disabilities program (MBIWPD); enrollees with incomes above 150% FPL will eventually be subject to an income-related premium.

and insurance holding companies (e.g., UnitedHealth Group) that own both types of licensees participate in New York's public insurance programs. Overall, commercial HMOs insured almost one-third of persons covered under the programs, and for-profit plans — including commercial health plans and for-profit PHSPs such as AmeriChoice, WellCare, and Amerigroup — enrolled a little over 20 percent of members (Table 20).

Rebounding from the exodus that occurred in the late 1990s due to their dissatisfaction with the rate-setting scheme, commercial health plans are experiencing a pickup in enrollment, which is helping to offset declines in employer-sponsored and individual coverage. For commercial HMOs, enrollment in MMC, CHP, and FHP made up 12.8, 3.9, and 3.5 percent, respectively, of their combined lines of business. As a senior official from an upstate health plan noted, "Commercial business is leaking, but safety net business is up."

Regional enrollment patterns for public programs are something of a "through the looking glass" version of commercial enrollment patterns. While upstate commercial markets are dominated by nonprofit health plans, upstate regional public markets — with the exception of the Syracuse area, in which Fidelis and Total Care dominate — are largely "PHSP-free zones." Enrollment is concentrated in one or two commercial HMOs, such as CDPHP, MVP/Preferred Care, or PHSPs sponsored by commercial health plans including Univera, part of the Excellus family.

And just as a handful of major commercial health plans square off in the downstate commercial market, a handful of muscular PHSPs compete head-to-head in the New York City public markets, where only commercial health plans HIP and the UnitedHealthcare/AmeriChoice combination are strong.

As is the case with the commercial markets, there is not a single health plan with a real statewide reach in all public markets. PHSP Fidelis is a top-tier health plan in New York City, its suburban counties, and throughout most of upstate, but has no presence in the Rochester region. Excellus, with its broad geographic sweep and strong partners in the Monroe County Health Plan and Univera PHSP, lacks access to the downstate market where public program eligibility is concentrated. UnitedHealthcare/AmeriChoice has a strong base in New York City and is expanding its reach in upstate public program markets.

Rates

To some degree, rate-setting rules for public programs resemble those in effect for commercial health plans prior to rate deregulation, although new changes are being phased in. Until recently, health plans submitted rate increase requests to the Department of Health for Medicaid Managed Care and Family Health Plus based on their own claims experience, expenses, and projections of medical trend. Within state funds appropriated for the programs and based on the state's overall projection of medical costs, rates were approved for each plan for a number of "rate cells" or categories of enrollees, broken down by demographics, aid categories (e.g., Temporary Assistance for Needy Families vs. SSI), and region. Health plans also compete for bonuses based on performance in quality measures selected by the Department of Health.

State rules cap health plan administrative expenses and, from time to time, state budget exigencies have resulted in arbitrary cuts in health plan reimbursement. So far the rate cuts, most recently in the fall of 2008, haven't resulted in health plan withdrawals from the programs, and PHSPs, which may not participate significantly in commercial markets, represent a captive audience.

Recently, DOH began implementing

Table 20. **Enrollment in State Public Programs in 2006 by Health Plan**

Article 44 HMOs	**Medicaid**	**Child Health Plus**	**Family Health Plus**	**Total**
AmeriChoice	94,265	1,333	15,466	111,064
CDPHP	35,548	18,425	6,665	60,638
Community Blue/HealthNow New York	30,189	13,978	7,819	51,986
Excellus Health Plan HMO	64,263	45,285	17,772	127,320
GHI HMO	13,124	2,969	6,526	22,619
HIP	189,331	3,218	51,058	253,607
Independent Health Association	25,150			25,150
Managed Health Inc.	2,273			2,273
MVP Health Care	3,347	1,545	1,365	6,257
Preferred Care	17,578			17,578
UnitedHealthcare of New York	63,610	2,180	25,596	91,386
WellCare of New York	61,204	12,744	29,68	103,628
Subtotal	599,882	111,677	161,947	873,506
Percentage of Enrollment by Program	30.4%	34.5%	32.6%	31.3%

Prepaid Health Services Plans	**Medicaid**	**Child Health Plus**	**Family Health Plus**	**Total**
Affinity Health Plan	134,408	28,577	43,244	206,229
Amerigroup	79,047	17,907	29,106	126,060
Centercare	55,471	4,117	10,010	69,598
Community Choice Health Plan	10,750	3,666	1,943	16,359
Community Premier Plus	64,724	3,021	8,550	76,295
HealthFirst PHSP	268,765	29,562	69,429	367,756
HealthPlus	186,918	24,951	44,286	256,155
Hudson Health Plan	34,677	19,354	7,472	61,503
MetroPlus Health Plan	186,902	18,432	37,451	242,785
Neighborhood Health	75,412	8,058	16,616	100,086
NewYork-Presbyterian	5,990	3,492	11,398	60,880
NYS Catholic Health Plan (Fidelis Care)	184,973	37,313	42,911	265,197
Suffolk County	10,786	3,817	72	10,786
Total Care (Syracuse Community Health Center)	18,450	3,284	3,302	25,036
Univera Community Health	17,441	6,201	9,425	33,067
Subtotal	1,374,714	211,752	335,215	1,917,792
Percentage of Enrollment by Program	69.6%	65.5%	67.4%	68.7%
TOTAL	1,974,596	323,429	497,162	2,791,298

Source: Author's analysis of Department of Health Medicaid Managed Care enrollment reports.

changes that it plans to phase in over the next four years. Under the new system, the categories of eligible beneficiaries will be compressed, with rates for plans based on the average of all plans in a region, adjusted to reflect each plan's population through a sophisticated formula that categorizes members in over 1,000 unique "clinical risk groups." State officials hope the new method will "smooth out" pronounced premium and expense differences between plans (see Tables 22 and 23, on the following pages, showing the wide spread among plans in these categories for the MMC and FHP programs), reward plans for efficiency and quality, and provide a platform for more careful management of the system and broader system reform focused on quality and outcomes.

Benefits

Unlike those in the commercial markets, health plans in public programs provide benefit packages that vary little from plan to plan, dictated by state and federal law and state plan amendments and waivers. DOH contracts with health plans prescribe benefits that are to be delivered by the plans with little variation, chiefly related to whether members obtain certain services (such as dental care) from the plan or through fee-for-service Medicaid. Some benefits, however, like prescription drugs, are often carved out of the benefit packages in public programs. Public program benefits are generally richer than those of commercial products, particularly with regard to long-term care services, and involve minimal cost-sharing, reflecting the incomes of the populations served.

Medicaid Managed Care

Although more commercial health plans participate in Medicaid Managed Care (twelve) than in Child Health Plus or Family Health Plus, MMC enrollment is the most "PHSP-centric" of the three programs, with only about 30 percent of enrollees signed up with commercial plans. Among those plans, HIP led the pack with almost 190,000 MMC members, followed by UnitedHealthcare/AmeriChoice with 156,000 and Excellus/Univera with 81,000 (Table 21).

Enrollment in PHSPs[143] downstate is concentrated in plans owned by or affiliated with hospitals or groups of hospitals. With enrollment of nearly 270,000, HealthFirst, affiliated with New York City voluntary hospitals, had the largest enrollment in 2006; its enrollment now approaches or surpasses that of some upstate health plans active in all markets. With about 185,000 enrollees each, three other plans with strong provider ties trailed HealthFirst in 2006: MetroPlus, affiliated with New York City's Health and Hospitals Corporation, and a regular chart-topper on the Department of Health's quality rankings for MMC plans; HealthPlus, affiliated with Lutheran Medical Center, an MMC program pioneer; and Fidelis Care, which grew from a plan affiliated with the Catholic health care system in Brooklyn and Queens to the one of the state's largest plans. The number of plans active in the New York City market is emblematic of the "embarrassment of riches" the DOH faces there in trying to implement policy changes.

All but two HMOs lost money on their MMC business in 2006, and almost half of the PHSPs suffered losses as well. Four PHSPs that profited, however — HealthPlus, Fidelis, Amerigroup, and HealthFirst PHSP — did very well, posting net gains of $13.4 million, $12.5 million, $8.8 million, and $7 million, respectively (see Table 19, above). On average, margins for MMC business were just 0.2 percent for PHSPs.

Medicaid recipients in New York, except

143 The Department of Health maintains enrollment figures on its website for all managed care plans operating in the public and private market. The information is updated regularly. http://www.health.state.ny.us/health_care/managed_care/report/2008/docs/march2008.pdf.

Table 21. **Enrollment in Medicaid Managed Care by Plan and Region, 2006**

REGION **HMOs**	1 **New York City**	2 **Long Island**	3 **Hudson Valley**	4 **Albany**	5 **Syracuse**	6 **Rochester**	7 **Buffalo**	**TOTAL**
AmeriChoice	87,883		485	351	5,517	27		94,263
CDPHP	3,462		111	29,477	1,872	1,043		35,965
Community Blue/HealthNow NY							30,189	30,189
Excellus Health Plan HMO				19	13,041	50,038	1,165	64,263
GHI HMO	9,226		2,858	405	635			13,124
HIP	163,953	21,194	55	13	9	4,100	7	189,331
Independent Health Association				6,207			18,943	25,150
Managed Health Inc.	1,399		100		443	439		2,381
MVP Health Care			3,347					3,347
Preferred Care						15,971	1,607	17,578
UnitedHealthcare of New York	27,879	7,519	12,518	3	14,160		1	62,080
WellCare of New York	48,984	68	9,337	2,691				61,080
Subtotal	342,786	28,781	28,811	39,166	35,677	71,618	51,912	598,751

REGION **Prepaid Health Services Plans**	1 **New York City**	2 **Long Island**	3 **Hudson Valley**	4 **Albany**	5 **Syracuse**	6 **Rochester**	7 **Buffalo**	**TOTAL**
Affinity Health Plan	104,583	14,653	15,172					134,408
Amerigroup	78,923		124					79,047
Centercare	55,471							55,471
Community Choice Health Plan	3,298	7,452						10,750
Community Premier Plus	64,724							64,724
HealthFirst PHSP	243,824	24,941						268,765
HealthPlus	190,533							190,533
Hudson Health Plan			34,677					34,677
MetroPlus Health Plan	186,902							186,902
Neighborhood Health	75,412							75,412
NewYork-Presbyterian	45,990							45,990
NYS Catholic Health Plan (Fidelis Care)	80,265	13,569	23,846	10,863	27,255		29,175	184,973
Suffolk County		10,786						10,786
Total Care (Syracuse Community Health Center)					18,450			18,450
Univera Community Health							17,441	17,441
2006 Subtotal	1,129,925	63,949	81,271	10,863	45,705		46,616	1,378,329
TOTAL Medicaid	1,472,711	92,730	110,082	50,029	81,382	71,618	98,528	1,977,080

Sources: Analysis of Medicaid Managed Care Reports (Department of Health) and New York State supplements for HMOs.

Table 22. **Medicaid Managed Care Per Member Per Month (PMPM) Highs and Lows -- Premiums, Medical and Hospital Expenses, Administrative Expenses, and Profits/(Loss)**

Health Plan	Premium PMPM	Medical and Hospital Expenses PMPM	Administrative Costs PMPM	Profit (Loss) PMPM
Hudson Health Plan	$226.37 (high)			
WellCare	$157.64 (low)			
Suffolk Health Plan		$215.91 (high)		
Community Choice		$133.62 (low)		
Community Choice			$44.14 (high)	
HealthNow			$18.40 (low)	
AmeriChoice				$13.26 (high)
MVP Health Care				($30.55) (low)
Statewide Average	**$187.28**	**$162.32**	**$25.16**	**($0.19)**

Source: New York State Department of Health, 2006 Annual Plan Statewide Reported Surplus and Loss Analysis.

for a limited number of people with special medical needs, are the only New Yorkers operating under an "individual mandate" of sorts.

Medicaid recipients in thirty-seven counties must join an MMC plan to use their health benefits; if they do not join a plan they are assigned one. Residents of another thirteen counties may voluntarily enroll in a plan; in the remaining twelve counties there is no plan available for enrollees. Some residents in these counties get care from physician groups to whom the state pays a special capitated rate.

Family Health Plus

Created as part of the HCRA 2000 initiative, Family Health Plus is the "youngest" of the public programs, and an expansion of Medicaid Managed Care. Since its inception, enrollment has steadily increased, reaching close to 500,000 in 2006. PHSPs control about two-thirds of FHP enrollment, with HealthFirst at nearly 70,000 members and HealthPlus, Affinity, and Fidelis with over 40,000 enrollees each. Among commercial health plans, HIP has the strongest enrollment, with over 50,000, followed by UnitedHealthcare and Excellus/Univera, each with 25,000. Empire, so strong in the CHP program, does not participate in FHP.

FHP is by far the most profitable of the public programs, with an average margin for PHSPs of almost 5 percent. Only two PHSPs lost money on FHP in 2006. Affinity, with over $23 million in net income from the program, earned triple the net FHP income of its closest competitor, Fidelis, with $7.1 million. Some observers believe that New

York State is still "catching up" on rates that were too high at the program's inception.

A core issue in New York's overall universal coverage strategy is the implementation of the FHP Buy-In and Premium Assistance programs. Under the Premium Assistance program (covering about 1,000 workers), FHP subsidizes the employee contribution to private employer-sponsored coverage for income-eligible workers, and supplements benefits. The FHP Buy-in program permits employer groups and unions to purchase FHP coverage at the full premium, and makes subsidies available to workers who meet income limits to offset the 30 percent employee cost share required under the program. The Department of Health is moving cautiously on the new initiatives. Thus far, it has focused on transitioning members of 1199 SEIU from a union Taft-Hartley fund subsidized by an annual HCRA allocation to the FHP buy-in program. Legislation to permit adjustments to the FHP benefits package as part of the FHP buy-in program was proposed, but not adopted, as part of the FY 2008/09 budget. It is a complex undertaking.

Key issues in the FHP Buy-In implementation include rate-setting, benefit design changes, health plan participation, rating methodology, applicability of rules and assessments that apply to commercial markets, and the question of whether current FHP individual enrollees will be pooled with employer purchasers. The larger issue is whether New York will seek to integrate its public and private program markets.

Child Health Plus

Predating mandatory MMC, FHP, and the authorization of PHSP licenses, Child Health

Table 23. **Family Health Plus Per Member Per Month (PMPM) Highs and Lows – Premiums, Medical and Hospital Expenses, Administrative Expenses, and Profits/(Loss)**

Health Plan	Premium PMPM	Medical and Hospital Expenses PMPM	Administrative Costs PMPM	Profit (Loss) PMPM
Group Health Inc.	$388.87 (high)			
Neighborhood Health Providers	$208.94 (low)			
MVP Health Care		$354.12 (high)		
Neighborhood Health Providers		$159.20 (low)		
Group Health Inc.			$49.58 (high)	
UnitedHealthcare			$25.26 (low)	
UnitedHealthcare				$22.22 (high)
MVP Health Care				($60.33) (low)
Statewide Average	**$252.98**	**$215.12**	**$33.60**	**$4.16**

Source: New York State Department of Health, 2006 Annual Plan Statewide Reported Surplus and Loss Analysis.

Plus is the oldest of the public programs. Its benefits and age eligibility levels have increased over time; reflecting that expanded eligibility and increased marketing efforts, CHP enrollment increased by 7 percent for commercial HMOs and over 20 percent for PHSPs in 2006, reaching almost 390,000 kids.

The program was intended, originally, to foster a commercial insurance market for children, but that dynamic changed somewhat with the advent of federal support for the program and New York's decision to "Medicaid" lower-income eligible children through the "CHP A" program. But today, CHP is still the "most commercial" of the public programs in terms of plan sponsorship, with enrollment split 47/53 between commercial HMOs and PHSPs. Empire leads all health plans in CHP enrollment, with more than 65,000 members, followed by Excellus, with over 45,000, and HIP, a leader for other public programs, with just 13,000. PHSPs with the greatest CHP enrollment include Fidelis, with 37,000 members, HealthFirst, with 30,000, Affinity, with 29,000, and HealthPlus, with 25,000 (Table 2).

With the exception of Affinity, which reported net income of $2.1 million, most PHSPs either lost money or posted modest gains on their CHP business, with an average margin of -2.6 percent in 2006. Empire gained $3.8 million from its CHP operation in 2006.

Reflecting the program's origins, CHP rates are still established by the State Insurance Department through a plan-by-plan prior approval process. Legislation to shift rate-setting to DOH is proposed annually.

Other Public Programs

In addition to MMC, FHP, and CHP, New York State's menu of public programs includes a number of initiatives targeting New Yorkers with special health care needs. These include the Managed Long-Term Care program, the Medicaid Advantage program, and HIV Special Needs Health Plans.

Managed Long-Term Care Plans. Over 23,000 New Yorkers[144] are enrolled in the Managed Long-Term Care (MLTC) program, the oldest and largest of the special needs managed care initiatives. Dating from a variety of demonstration programs that were developed in the 1990s, the MLTC program is designed to help people who need health and long-term care services, such as home care and adult day care, to enable them to stay in their homes, while reducing Medicaid long-term care expenses. The array of pilot projects was given a statutory framework in 1997;[145] as a result of DOH regulations issued in 2005, MLTC plans must now comply with requirements applying to regular managed care organizations.[146] Statutory provisions limit the number of plans that may be authorized to sixteen.

There are two main models of MLTC in the state, the Program of All-Inclusive Care for the Elderly (PACE) and partially capitated managed long-term care plans. Four PACE sites provide comprehensive services and are approved by CMS and reimbursed on a capitated basis by both Medicaid and Medicare. Twelve prepaid managed long-term care plans, paid on a capitated basis by Medicaid, provide care management, long-term care services, durable medical equipment, nutrition, optometry, physical therapy, dentistry, and ancillary services.

Enrollment is voluntary, and is concentrated both in New York City and in the partially capitated plans. Almost 90 percent of enrollment represents residents of New York City who are members of the ten plans operating there; only five plans operate upstate. Statewide, 85 percent of members

144 New York State Office of Health Insurance Programs. March 2008. New York State quarterly managed care enrollment report.

145 Chapter 659 of the Laws of 1997.

146 10 NYCRR Part 98-1.

are enrolled in the twelve partially capitated MLTC plans. The largest plans are Guildnet (6,744 members), VNS Choice (5,743 members), Homefirst (2,361 members), and Independent Care Systems, Inc. (1,300 members).[147]

Medicaid Advantage Plans. Authorized in 2005, Medicaid Advantage Plans are designed to provide Medicaid Managed Care wrap-around coverage for dually eligible residents (those eligible for both Medicaid and Medicare) who are receiving their Medicare coverage through a Medicare Advantage plan (discussed below). Over 4,100 New Yorkers are enrolled in these plans.[148] As of December 2007, enrollment was concentrated in New York City, with over 3,500 members, and within HIP, with 1,600 members.[149]

HIV Special Needs Plans. Authorized in 1998 but slow to take root, HIV Special Needs Plans opened enrollment in 2003 to offer people living with HIV/AIDS, and their dependents, an alternative to Medicaid fee-for-service or Medicaid Managed Care plans. Three plans operating in New York City — MetroPlus' Partnership in Care, NewYork-Presbyterian Health Care System SelectHealth, and VidaCare — enroll about 3,255 individuals.[150]

(For a more thorough review of the Medicaid and Medicaid Managed Care programs, see Birnbaum M. 2008. *Medicaid in New York: A Primer: Revised and Updated 2008*. For a more expansive examination of the issues facing the state Medicaid Managed Care program, see Sparer M. 2008. *Medicaid Managed Care Revisited.* Both are available online at www.uhfnyc.org.)

147 New York State Department of Health. December 2007. Recipients eligible for enrollment in managed care: Enrollment status by aid category and county, and total percent enrolled by provider plan.

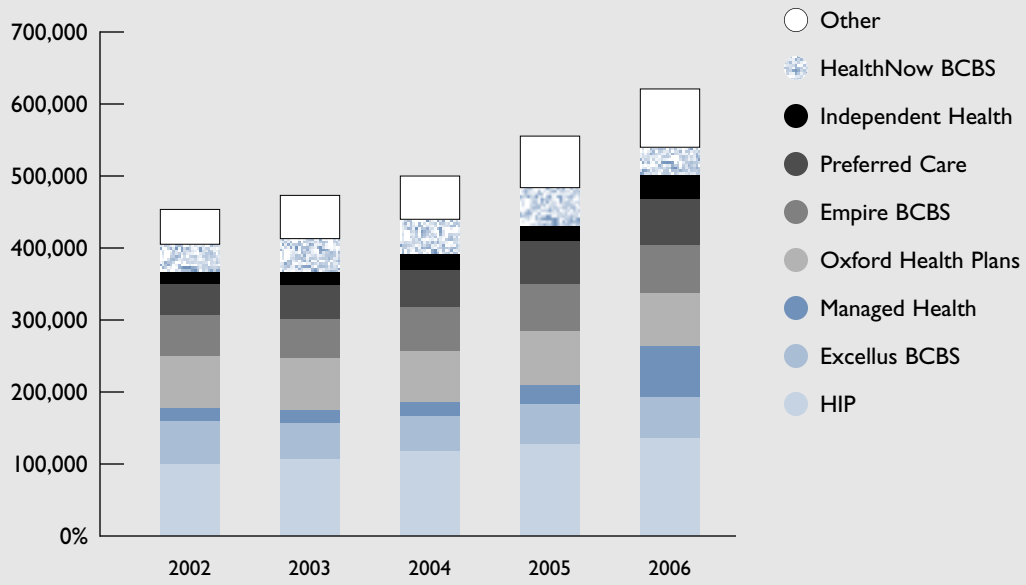
148 Ibid.

149 Ibid.; and New York State Department of Health. June 2006. Medicaid Advantage enrollment report.

150 New York State Department of Health. August 8, 2008. "Choices in Care" ranks HIV care in special needs managed care plans as superior to traditional Medicaid. [Press release]

Part V: Medicare

Figure 7. **Medicare Advantage Enrollment, 2002 to 2006**



Source: Author's analysis of health plan NAIC annual statements, 2002-2006, Exhibit of Premiums, Enrollment and Utilization.

With almost 2.8 million aged and disabled beneficiaries, New York State ranks third among states in total Medicare enrollment.[151] Covering the gaps in Medicare coverage for these enrollees remains a significant cost for state and local governments, through the Medicaid program, and for businesses offering retirement health benefits to workers.

Changes in the Medicare program creating new options to supplement traditional Medicare have become an increasingly important source of revenue for health plans offering traditional supplemental coverage, Medicare Advantage (Part C), and prescription drug (Part D) products.

An estimated 16 percent of enrollees nationally have no supplemental insurance coverage accompanying their Medicare benefit; one-third to one-quarter rely on employer-sponsored coverage to fill the gaps in their Medicare benefits.[152] In New York, more than 600,000 dual eligibles receive varying degrees of Medicaid support based on their income, assets, and health conditions. Over 680,000 residents are enrolled in Medicare Advantage programs, either individually or through their employers;

151 Centers for Medicare & Medicaid Services. CMS statistical tables: Medicare enrollment, aged beneficiaries, as of July 2006, and disabled beneficiaries, as of July 2006.

152 Centers for Medicare & Medicaid Services. January 31, 2007. *An overview of the U.S. health care system* [chart book].

about 400,000 purchase individual Medicare Supplement or "Medigap" policies; and almost 1,000,000 are enrolled in stand-alone Part D prescription drug programs.

Employer-Sponsored Supplemental Coverage

In arrangements that predate both the Medicare Advantage program and its precursor, the Medicare + Choice program, many Medicare enrollees receive supplemental benefits from union or employer retiree health benefit plans, although those numbers are shrinking. These benefits can be fully insured or self-funded and administered by health plans or third-party administrators. As noted earlier, public employer plans such as NYSHIP, the New York City benefits plan, and the FEHBP are significant providers of supplemental coverage, serving more than 580,000 Medicare beneficiaries and their dependents in New York. For these arrangements, public employers often purchase the same policy for their active and retired employees, but offer group Medicare Advantage coverage as well.

Medicare Advantage

Since Medicare Advantage can be purchased on a group basis as well as by individual Medicare enrollees, some private employers in New York now offer retirees access to group Medicare Advantage coverage. Five of the top fifteen writers of employer-only MA enrollment — including HIP, Excellus, and MVP/Preferred Care — are either domiciled or active in New York.[153]

Over 680,000 New Yorkers (about 24 percent of state Medicare beneficiaries) are covered under either employer-sponsored or individual Medicare Advantage. Beneficiaries can select HMO, PPO, private fee-for-service, Health Care Pre-Payment Plan (HCPP), Social HMOs (SHMOs), or Program of All-Inclusive Care for the Elderly (PACE) coverage. Medicare Advantage plans typically offer reduced out-of-pocket costs, including Part B and Part D premiums, and additional benefits such as vision and hearing services, or coverage of emergency care in foreign countries. Most MA enrollees access their Part D drug benefit through the program. Some of the coverage choices — HMOs, for example — predate the 2003 Medicare Modernization Act; others, such as private fee-for-service, were added later as new coverage options.

Enrollment

New York ranked twelfth among all states in overall Medicare Advantage market penetration in 2007.[154] Over 80 percent of New York's MA enrollees are in HMOs, 7 percent are in PPO programs, 4 percent are in private fee-for-service, and the remainder are in smaller, more specialized options, such as HCCPs or SHMOs, programs that provide specialized services for the frail elderly (see Table 24). Several recent analyses have reported sharp growth nationally in private fee-for-service plan enrollment, much of which has occurred in the past year and would not show up in data collected in July 2007. On the other hand, more than 95 percent of New Yorkers have access to three or more managed care Medicare plans statewide.

Although the Medicare Modernization Act of 2003 largely preempted state insurance regulation to open up MA markets nationwide to any "risk-bearing entity," enrollment in New York is centered in state-licensed HMOs that are overall market leaders in their regions, rather than out-of-state health plans or the new "senior-only" companies that

153 Gold M. June 2008. *Medicare Advantage in 2008.* The Henry J. Kaiser Family Foundation.

154 The Kaiser Family Foundation Medicare Health and Prescription Drug Plan Tracker. May 2009. http://healthplantracker.kff.org/topicresults.jsp?i=8&rt=2.

Table 24. **New York Enrollment in Medicare Advantage Plans, July 2007**

Health Plan	HMO	Private Fee-for-Service	Local PPO	Regional PPO	Cost, HCPP	PACE, SHMO	TOTAL
Aetna Health/Life	12,714	772	686				14,172
Affinity Health Plan						339	339
American Progressive Life/Health		22,341					22,341
AmeriChoice	742						742
Boro Medical Center					1,579		1,579
Cambridge Life Insurance		256					256
CDPHP	13,049						13,049
Comprehensive Care Management						1,870	1,870
ElderPlan	108					16,574	16,682
Empire HealthChoice HMO/Assurance	66,554	2,107					68,661
Excellus Health Plan HMO	48,387		17,928		5,060		71,375
Group Health Inc.			9,876				9,876
Health Net of New York	6,129	1,827					7,956
HealthNow New York	32,483		11,883				44,366
HIP	124,456				2,111	126,567	
Humana Medical Plan/Insurance Company	291	1,630					1,921
Independent Health Association	43,550						43,550
Liberty Health Advantage						1,685	1,685
Managed Health Inc.	55,331						55,331
MCS Advantage	111						111
MMM Healthcare	134						134
MVP Health Care	1,384						1,384
Neighborhood Health Providers	1,949						1,949
New York State Catholic (Fidelis Care)	1,287						1,287
New York Hotel Trades					3,425		3,425
Oxford Health Plans	68,650						68,650
Preferred Care	62,277		310				62,587
Stone Harbor Insurance		1,332					1,332
Touchstone Health Partners						3,171	3,171
United HealthCare Insurance Co. of NY	10,033			6,749			16,782
WellCare New York/Florida	18,343						18,343
TOTAL	567,962	28,158	42,790	6,749	12,175	23,639	681,473

Companies with fewer than 100 enrollees not shown here. CMS reports do not list enrollment when there are fewer than ten enrollees in a county for a particular health plan.
Source: Author's analysis of CMS State County/Contract/Medicare Advantage Monthly Enrollment report for July 2007.

have developed almost overnight to specialize in this business. With enrollment of over 120,000, HIP leads the pack, followed by Oxford, Empire, MVP/Preferred Care, Excellus, and HealthNow.

Three other enrollment-related trends are worth highlighting. Managed Health Inc.'s enrollment of over 50,000 MA members is significant; as part of the HealthFirst PHSP holding company, having enrolled that number represents a bold entry by a PHSP-structured health plan into a Medicare Advantage market dominated by traditional HMOs and insurers specializing in this market. American Progressive Life — part of the Universal American holding company structure, whose enrollment has grown exponentially nationwide — reported over 20,000 private fee-for-

service members, more than 80 percent of that market statewide in New York (although both HealthNet and WellCare are making inroads as well). Finally, mirroring national trends, enrollment in MA Special Needs Plans (SNPs) has also grown rapidly in New York.

SNPS

Added to the menu of managed care options in the Modernization Act, Medicare Advantage Special Needs Plans were authorized to provide coordinated care to three special needs populations: 1) dual eligibles; 2) patients and residents of institutions; and 3) the chronically ill. SNPs for Medicare recipients have become a growing subset of the MA program nationally. The number of plans grew from just eleven in 2004 to almost 500 in September 2007, and enrollment nearly doubled to over 1 million beneficiaries between 2006 and 2007.[155] In New York State, enrollment grew from 70,000 to 90,000 between 2007 and 2008.[156] Nationally, over 70 percent of Medicare Advantage SNP enrollees are dual eligibles, 17 percent suffer from chronic or disabling conditions, and 11 percent are institutionalized.[157] In New York, the vast majority of enrollees — nearly 73 percent — are dual eligibles; institutionalized persons account for 26 percent of enrollment, and beneficiaries with chronic conditions, mainly diabetes, make up almost 2 percent.

Five health plans represent more than 90 percent of total SNP enrollment in New York: Managed Health with over 37,000, Elderplan with over 16,000 institutionalized enrollees, UnitedHealth Group with over 10,000, Wellcare with over 8,900, and HIP with over 7,800.

In a spirited national debate over the future of the Medicare Advantage program, critics charge that MA plans are paid far more than the payments for original Medicare enrollees. Too great a share of health plan rebates goes toward profits rather than toward additional benefits to beneficiaries, they claim, and MA payments are boosting the cost to original Medicare enrollees. Defenders say the program has enhanced benefits and reduced out-of-pocket expenses for enrollees, particularly those in rural areas, and represents a significant improvement over original Medicare. One thing is certain: the MA payment system has been very profitable for plans participating in New York.

New York HMOs alone earned over $400 million in net income from their MA business in 2006. On average, MA revenues represented over 40 percent of net income for all lines of business for HMOs — ranging from a low of 22 percent for Empire, which posted positive results in nearly all product lines in 2006, to over 80 percent for Independent Health.

Medigap

Until the enactment of the Medicare Modernization Act, Medigap or "Med Supp" policies were the only game in town for Medicare beneficiaries wishing to purchase a drug benefit, insurance to cover Medicare cost-sharing for Part A and Part B services, or certain additional benefits not covered by Medicare. Although state insurance regulators refer to it as a "declining block of business," Medigap policies were purchased by nearly 400,000 New Yorkers in 2007,[158] despite the introduction of the Part D drug benefit. UnitedHealthcare (through its joint arrangement with AARP) and Empire BlueCross BlueShield are two of the leading providers

155 Milligan CJ and CH Woodcock. February 2008. *Medicare Advantage special needs plans for dual eligibles: A primer.* New York: The Commonwealth Fund.
156 Centers for Medicare & Medicaid Services. July 2007 and July 2008. *Special needs plan comprehensive report.*
157 Ibid.
158 New York State Insurance Department.

of Medigap coverage in New York, reporting $19 million and $18 million in net income, respectively, from their Medigap products in 2006.

Within the federally mandated standardized benefit packages (designated A through L, and distinguished by different levels and combinations of benefits), state regulators, trade groups, and consumer advocates report that Products B, C, and F are the most popular Med Supp offerings.[159] Generally, eight to ten carriers currently offer those three types of policies in various regional markets across the state, at monthly premiums ranging from $127.29 for a Plan B offered by Empire in Albany, to $343 monthly for a State Farm Mutual Auto Plan F purchased in Long Island.[160] Plans B, C, and F cover some or all of Medicare Part A coinsurance and Part B co-payments, Part A and Part B deductibles, and, to various degrees, additional services such as care in a skilled nursing facility. Premiums paid for coverage are in addition to enrollees' responsibility for Part B premiums.

Medigap products in New York are community-rated, so premiums are the same for all New York policyholders, regardless of their ages. Some states allow "issue-age rated" policies that allow younger purchasers to lock in lower rates, and policies with automatic increases as policyholders age, known as "attained-age rating."

Part D

Almost one million New York Medicare beneficiaries are enrolled in stand-alone Part D prescription drug plans (Table 25). Like the Medicare Advantage market, health plans active in New York's commercial or

159 America's Health Plans, Center for Policy and Research. March 2008. *Trends in Medigap policies, December 2004 to December 2006* reports that 40 percent of 10 million Medigap enrollment nationally is in Plan F and 20 percent is in Plan C.

160 New York State Insurance Department. Rates as of January 1, 2008.

Table 25. **Enrollment in Part D Medicare Stand-Alone Prescription Drug Plans, 2007**

UnitedHealthcare Insurance Co.	168,131
Humana Insurance Company	154,502
UnitedHealthcare Insurance/New York	124,100
American Progressive Life and Health	66,783
WellCare Prescription Insurance	61,532
Excellus Health Plan	56,957
HIP	56,840
UniCare Life and Health (BCBS)	48,004
Cambridge Life Insurance	42,381
Health Net Life Insurance Co.	39,815
Group Health Inc.	36,600
Connecticut General Life (Cigna)	30,156
MemberHealth, Inc.	18,502
Silverscript Insurance	18,281
RxAmerican LLC	15,079
Bravo Health Insurance	12,437
HealthSpring Inc.	9,462
First United American Life	7,770
MEDCO Containment Life Insurance	4,637
Aetna Life Insurance	4,234
The Port Authority of NY and NJ*	1,663
Sterling Life Insurance	1,461
Other Plans	2,818
Total	982,145

Notes: December 2007 enrollment in part D plans, sorted by size. According to StateHealthFacts.org, there are 2,860,851 Medicare recipients in New York.
* Employer/union only direct contract PDP.

Source: Author's analysis of monthly data report (December 2007) from Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MPDPESCC/list.asp#TopOfPage.

public markets have a dominant market share. Seven of the top ten Part D plans have strong domestic presences in New York; Kentucky-based Humana, one of the largest Medicare plans nationally, enjoys significant enrollment, with over 150,000 members; private fee-for-service specialist American Progressive (a subsidiary of Universal American) enrolls nearly 67,000 members; and WellCare has 61,000. UnitedHealthcare companies control almost one-third of the Part D market in New York, with nearly 300,000 members.

Appendix A: Useful Insurance Terms

Cost-sharing. An increasingly important feature of all types of health coverage, cost sharing reduces premiums by increasing enrollees' out-of-pocket costs, and deters utilization. The most common forms of cost-sharing include:

- **Deductibles.** A deductible is a fixed dollar amount during a benefit period (usually one year) that a consumer must pay before the health plan begins making payment for covered services. Deductible amounts usually vary according to the number of people covered under the contract (i.e., individuals versus families). Separate deductibles may also apply for specific benefits, such as prescription drugs, or each time a particular covered service — such as emergency care or inpatient or outpatient surgery — is used. In New York, HMOs are not permitted to charge deductibles for comprehensive managed care products.

- **Coinsurance.** Coinsurance is a form of cost-sharing that kicks in after patients meet their deductible amount, if any. It is typically calculated as a percentage of the cost of a covered service, up to an out-of-pocket maximum. Once the out-of-pocket coinsurance maximum is reached, the health plan reimburses for the full cost of the services, according to the terms of the contract. Two different sets of coinsurance maximums may apply, for in-network and out-of-network services. Under some plan designs, even after the coinsurance maximum is met, consumers may still have out-of-pocket expenses, such as the difference between the health plan's fee schedule and the provider's charges.

- **Co-payments.** Co-payments or "co-pays" are fixed dollar amounts that health plans require enrollees to pay to providers in return for specified services. Health plans typically offer employer groups co-payment schedules ranging from $5 to $50 per visit. Co-pays can also vary for specific types of services. Increasingly common "split co-pay" plan designs charge one (usually lower) co-pay for primary care services and another for specialty or other services. New York regulations limit the amount of co-pays that HMOs can require.

- **Tiered Pharmacy Benefits.** Reflecting growing costs of prescription drugs, many pharmacy benefit designs incorporate some or all three types of cost-sharing, which are often applied in "tiers" based on the type of drug. Deductibles are increasingly common in all types of pharmacy benefits. Many plans have adopted "three-tier" pharmacy benefits, under which co-payments vary, ranging roughly from $0 to $70, depending on how a drug is categorized: 1) a low co-pay for generic drugs; 2) a higher co-pay for name-brand drugs (often called "preferred" drugs) that are on a health plan's formulary; and 3) the highest co-pay for "non-preferred" name-brand drugs that are not on the formulary. More recent — and controversial — plan designs simply require consumers to pay uncapped coinsurance on all prescription drugs once overall drug spending exceeds a certain amount, or add a fourth tier under which coinsurance applies, typically for rarer drugs such as "biologicals" or self-injectables. State Insurance Department regulations restrict the use of some of these newer designs. Benefit caps on

prescription drugs are also increasingly common, as are plans that offer only drug discount cards, or no prescription drug coverage at all.

Exclusive Provider Organization (EPO). An EPO is a less restrictive managed care model, under which participants must use providers from a network organized by the health plan; there is typically no coverage for care received from a non-network provider, except in an emergency. In New York, EPOs are offered both with a gatekeeper function and with direct access to network providers.

Health Maintenance Organization (HMO). An HMO is an integrated health care system that assumes both the financial risks associated with providing comprehensive medical services and the responsibility for health care delivery to members. Enrollees must obtain referrals and prior authorization for all services, and are limited to providers that have agreed to accept the HMO fee as full payment for the services provided.

High Deductible Health Plan (HDHP). High deductible health plans are fully insured products with high deductibles, generally at least over $1,100 for individuals and as much as $10,000. The products are typically marketed in tandem with tax-favored savings accounts, which enrollees can use to pay the deductible amounts. There is no requirement that purchasers of HDHPs or employer groups that offer them actually establish the special accounts. Some health plans own banks that earn fees on the accounts. The accounts fall into two main categories:

- **Health Savings Accounts (HSAs)** are governed by IRS rules and can be used with HDHPs with minimum deductibles of $1,100 ($2,200 for families) and maximum out-of-pocket limits of $5,600 for individuals ($11,200 for families). Employers and employees can make deposits into the accounts. Employer contributions are excluded from employee gross income and employee contributions are tax-exempt. The maximum deposit permitted in 2008 was $2,900 for self-only coverage and $5,800 for family coverage. Account balances can be rolled over into succeeding years, and funds can only be spent for qualified medical expenses.

- **Health Reimbursement Arrangements** are funded solely by employers, with contributions excluded from employees' income. There are no limits on employer contributions.

Indemnity Coverage. Once the prevailing way health care was financed, indemnity coverage is increasingly rare. Under this arrangement, health plans reimburse the patient as medically necessary expenses covered by the policy's terms are incurred. Under a conventional indemnity plan arrangement, the patient's choice of provider does not affect reimbursement.

Participating Provider Organization (PPO). Contrary to the common perception, PPOs (also known as Preferred Provider Organizations) are not licensed insurers. In the context of fully insured arrangements, a PPO is a type of indemnity policy in which participants are covered through a network of selected health care providers that have contracted with the health plan. The providers are called "Par" providers, because they participate in the network. Enrollees may also obtain services outside the network (non-Par providers), but incur greater costs in the form of higher deductibles, coinsurance rates, and non-discounted charges from providers. PPOs typically do not require referral from a "gatekeeper" or primary care physician to access services either within or outside the network. Payment for services from in-

network providers is typically made directly to the provider; for out-of-network services, consumers pay out of pocket and are reimbursed by the health plan. In the past, PPO products held enrollees harmless from out-of-pocket costs when in-network providers were used. Enrollees "assign the benefit" to providers, and providers accept the plan's payment as payment in full. Today, many health plans impose cost-sharing on both in-network and out-of-network services in PPOs.

Health plans and third-party administrators of self-funded plans sometimes arrange for services to be provided to enrollees through networks of participating providers, and these also may be known as PPOs. The plan sponsor, such as an employer group or union, pays a per-member-per-month fee for the use of the network, reflecting the discounted rate for services negotiated with the providers by the plan administrator. There are many companies, also known as PPOs, that are not licensed insurers but instead organize the networks of providers and market them for use by fully insured or self-funded benefit plans. These companies are also known as "leased network" or "rent-a-network" companies.

Point-of-Service (POS) Plan. POS plans resemble PPOs, but combine managed care and indemnity plan features to allow consumers to access services through in-network HMO providers, or through out-of-network providers at additional cost.

Pre-existing Condition. A pre-existing condition is a condition, either physical or mental, and regardless of the cause, for which medical advice, diagnosis, care, or treatment was recommended or received by a consumer within the six-month period ending on the date the individual enrolls in health coverage.

Pre-existing Condition Provision. A feature of most health insurance contracts, these provisions, also known as "waiting periods," are designed to protect against adverse selection from people who delay the purchase of health coverage until they have a pressing medical need for it. Changes adopted as part of the 1992 community rating law (and later incorporated into the federal Health Insurance Portability and Accountability Act) prevent health plans from medically underwriting coverage through the application of pre-existing condition provisions. Before the enactment of the law, health plans could include open-ended benefit exclusions in policies that were related to pre-existing conditions, and reject applicants due to certain conditions. Under New York's laws and HIPAA:

- Health care policies must cover all treatment unrelated to the pre-existing condition, and coverage for treatment related to the pre-existing condition can be excluded for no longer than twelve months; and
- In calculating the length of a pre-existing condition exclusion or waiting period, a health plan must credit toward the twelve-month maximum any period of continuous coverage — i.e., without a lapse of more than sixty-two days — by a different health plan.

HIPAA requires health plans to provide individuals terminating their coverage with a "certificate of creditable coverage" to make it easier for them to document past coverage when they enroll in a new plan. Many, but not all, employer groups purchase riders that provide coverage for workers with pre-existing conditions once they have become eligible for group health insurance benefits.

Here are three examples of how New York's law works.

- Ms. X has been treated for asthma recently, but has never had health insurance. When

she applies for individual coverage for the first time, the health plan accepts her but is permitted to impose a pre-existing condition limitation related to her asthma. Ms. X's other medical needs are covered under the policy's terms, but with no prior coverage to apply toward the twelve-month limitation, treatment for her asthma is an out-of-pocket expense for one year.

- Mr. Y, who also has asthma and has newly applied for coverage, had other insurance for the preceding six months, without a gap in coverage, through his last job. He must pay out of pocket for asthma treatment for six months — twelve months minus a six-month credit for his prior coverage.
- Ms. Z has a heart condition, but when she applies for coverage, she presents her "Certificate of Creditable Coverage," required under the federal Health Insurance Portability and Accountability Act (HIPAA). The new health plan notes that she was previously covered under COBRA for eighteen months, so it cannot apply a pre-existing condition limitation on her benefit. When Ms. Z has surgery related to her heart condition six months later, it is covered in full, subject to any cost-sharing provisions that apply to all treatment under the policy, since the prior creditable coverage eliminates any permissible waiting period.

These limitations on the use of pre-existing condition provisions made coverage "portable," since they allowed individuals to switch jobs or health plans without exclusions related to pre-existing conditions, as long as their coverage was continuous.

Usual, Customary, and Reasonable (UCR). "Usual and Customary" or "Usual, Customary, and Reasonable" is the phrase that describes the mechanism many health plans use to determine the amount that consumers will be reimbursed for health care services, typically in an indemnity policy, or a policy that allows enrollees to see providers outside the health plan's network. UCR charges are schedules that show the "prevailing rates" that providers in a given region charge for a service. Sometimes the schedules are developed by health plans themselves, but more often they are purchased from an outside vendor. The actual payment a consumer receives is usually a percentage (generally between 50 and 80 percent) of the amount on the schedule for a particular service. Consumers are responsible both for the difference between the percentage and 100 percent of the UCR, and the amount by which the provider's charge exceeds the health plan's UCR charge for that service. An investigation by Attorney General Cuomo is changing the rules for UCRs in New York and across the nation (see "The Attorney General Weighs In," page 47).

Appendix B: Regional Markets

Region I:
New York City
Counties:
Bronx, Kings, New York, Queens, Richmond
Under-65 population:
7.2 million

New Jersey and Connecticut natives and residents of New York's suburban counties spill off their commuter trains each day heading for their jobs — and their health insurance. Since health plans report their group enrollment by the site of each business rather than where enrollees live, the New York City region — really a tristate region — captures commercial group enrollment of nearly five million from the city, its suburbs, and neighboring states.

The region's fully insured group market includes three dominant health plans — HIP/GHI, Oxford/UnitedHealthcare, and Empire BlueCross BlueShield (see accompanying table, "Regional Enrollment in Comprehensive Employer Group Coverage"). While the nonprofit HIP/GHI companies score a high percentage of the market, much of their enrollment can be attributed to public employees. The companies' niche among non-public-employer groups is the "low price point" market. Oxford/UnitedHealthcare and Empire enroll the greatest number of employer groups in both the Large (over fifty employees) and Small (50 or fewer employees) Group markets, the latter a market of "lots and lots of really small three- and four-person groups," as an Oxford Health Plan official noted.

In some ways, the New York City regional market is best viewed through a prism, Empire's new "Prism" line of products, to be exact. Launched in 2008, brokers and the company's competitors agree that the Prism line has been "eating everyone's lunch." Targeting small and medium-size businesses (of up to 300 employees), it is offered through a variety of benefit platforms, such as EPOs and PPOs.

Oxford/UnitedHealthcare operates largely through the Oxford brand in the downstate region (upstate, UnitedHealthcare predominates). While the companies are frequently the target of enforcement actions, litigation, and criticism by providers, consumer groups, and state regulators, because of payment practices, brokers report that Oxford remains a force, due to its Liberty and Freedom provider networks and the strength and diversity of its product lines. United is a top player in the self-funded market through its UnitedHealthcare National Accounts subsidiary.

In addition to the three market leaders, New York City employer groups can choose from a second tier of well-known health plans such as Cigna, Aetna, and HealthNet. Companies in the second tier don't have the size to drive the largest provider discounts that United and Empire do. As one broker noted, "You still get the best deal from the big guys." Aetna works at convincing hospital and other providers of the value of a "third player," though, and works to attract employer groups with tools other than the deepest discounts on provider rates.

Aetna officials call New York their fourth largest region nationally, with over one million "medical members," between self-funded and fully insured enrollment. Company officials tout their ability to offer employer groups a full range of services — vision, dental, health insurance, life, disability, chronic disease

Regional Enrollment in Comprehensive Employer Group Coverage, 2006

Region **Article 44 HMOs**	1 **New York City**	2 **Long Island**	3 **Hudson Valley**	4 **Albany**	5 **Syracuse**	6 **Rochester**	7 **Buffalo**	**TOTAL**
Aetna Health	77,919	38,229	42,690		1,361			160,199
Atlantis Health Plan	9,350	1,130						10,480
CDPHP	20	4	8,838	137,663	34,879	10	7	181,421
Cigna Healthcare	9,172	3,746	2,759	129	3	16		15,825
ConnectiCare of New York			34					34
Empire HealthChoice HMO	121,447	177,046	58,062	20,621	4,163	367	13	381,719
GHI HMO	3,281	355	20,404	3,184	1,113	6	341	28,684
Health Net of New York	105,762	16,993	15,762	3,277	3,338	1,670	8,349	155,151
HIP	427,651	84,700	14,345	20,895		2	99	547,692
Independent Health Association							197,231	197,231
Managed Health, Inc.	8	6						14
MDNY Healthcare		23,563						23,563
MVP Health Care	75	24	75,943	72,281	68,832	173	17	217,345
Oxford Health Plans	261,167	62,510	52,185	25,957	27	1	343	402,190
Preferred Care	1,841	538	11	43	516	104,670	4,371	111,990
UnitedHealthcare of New York								
Subtotal	1,017,693	408,844	291,033	284,050	114,232	106,915	210,771	2,433,538

Region **Article 43 Nonprofit Insurers**	1 **New York City**	2 **Long Island**	3 **Hudson Valley**	4 **Albany**	5 **Syracuse**	6 **Rochester**	7 **Buffalo**	**TOTAL**
CDPHP Universal Benefits	30	30	4,282	28,185	7,838	18	3	40,386
Excellus Health Plan	1,610	1,256	778	231,455	529,303	599,457	137,346	1,501,205
Group Health Inc.	1,405,178	36,824	9,609	31,090	12,799	4,815	49,915	1,550,230
Health Insurance Plan of Greater New York	1,186	8,705	7					9,898
HealthNow New York	189	24	342	96,860	14,007	824	338,741	450,987
Independent Health Benefits							17,621	17,621
Preferred Assurance						706	122	828
Subtotal	1,408,193	46,839	15,018	387,590	563,947	605,820	543,748	3,571,155

Region **Article 42 Accident/Health Insurers**	1 **New York City**	2 **Long Island**	3 **Hudson Valley**	4 **Albany**	5 **Syracuse**	6 **Rochester**	7 **Buffalo**	**TOTAL**
Empire HealthChoice Assurance*	1,285,618	370,898	236,905	227,149	127,730	34,474	41,283	2,324,057
Health Net Insurance of New York	24,731	13,507	27,822	966	48	74	21	67,169
Horizon Healthcare Insurance Company of NY	14,569	5,140		1	1			19,711
MVP Health Insurance	37	14	2,733	2,869	4,068	57	10	9,788
Oxford Health Insurance	586,796	178,051	129,240	22,221	755	3	37	917,103
PerfectHealth	917	546	593	7	15	1	550	2,629
UnitedHealthcare Insurance	479, 941	238, 907	194, 959	90, 923	131,080	48, 170	65, 721	1, 249, 701
Subtotal	2,392,609	807,063	592,252	344,136	263,697	82,779	107,622	4,590,158
TOTAL	4,818,495	1,262,746	898,303	1,015,776	941,876	795,514	862,141	10,594,851
Population Under 65	7,169,869	2,355,691	1,943,295	1,231,965	1,435,112	1,066,483	1,263,953	16,466,368

Notes: Enrollment for HMO line of business for HealthNow and Excellus included with HDMI parent company.

* Enrollment based on county of employer except for Empire HealthChoice Assurance enrollees in state employees group, where state data are used to allocate enrollment by county of residence.

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

management, and wellness — from under one integrated roof. Once the subject of the same type of adverse publicity that UnitedHealthcare now receives, Aetna is lately earning praise from provider groups for its innovations. "We're doing some interesting things with Aetna," said an executive at a downstate hospital system.

In 2008, Aetna also rolled out a special product targeting New York City's uninsured small businesses. The New York City Community Plan is a low-cost, in-network-only plan under which members can avoid coinsurance, deductibles, lifetime maximums, and preventive care co-pays for a wide range of services by seeing a smaller network of preferred providers. Company officials say that an extensive effort was made to secure culturally and linguistically diverse providers operating in New York's ethnic communities, and the company has worked to market the product through community-based organizations as well. Although enrollment is modest thus far, Aetna seems committed to the product, which it sees as working hand in hand with its health care disparity efforts.

HealthNet, a publicly traded company headquartered in California, operates in the Northeast through its Shelton, Connecticut, office. In 2007, HealthNet and Guardian ended a long-term collaboration on an HMO/POS product known as HealthCare Solutions, when HealthNet bought out Guardian's interest. Guardian, the last of the New York life insurers remaining in the commercial market, plans to stay there, motivated by the desire to continue offering employer groups a complete line-up of life, health, and disability products; it sees its niche as a purveyor of quality products without the managed care features that have drawn consumers' ire. Although current enrollment has declined to less than 30,000 covered lives in the Small and Large Group and self-funded markets, the company is awaiting approval of new products to replace the plan it offered with HealthNet.

Cigna — which has announced plans to withdraw its HMO products from New York — is an example of a company that flies beneath the radar to an extent, due to the less detailed reporting for national insurers not operating through New York domestics, and data shortcomings in the self-funded market. Cigna, Oxford/UnitedHealthcare, Empire, Aetna, and HIP/GHI (particularly for union plans) all compete aggressively in the self-funded market. If fully insured and self-insured markets were combined, one observer estimated in 2004, Cigna, Aetna, and United each would have had market shares of over 10 percent downstate, while Empire's would have been about 25 percent.[1]

Region 2:
Long Island
Counties:
Nassau, Suffolk
Under-65 population:
2.36 million

The New York City region's top three health plans — Empire, Oxford/UnitedHealthcare, and HIP/GHI — also have the biggest market shares in the 1.2 million-member Long Island group market. Enrollment in the state's public employee health insurance program, in which Empire, United, and GHI all participated in 2006, is very important to the region; nearly a third of the Empire Plan's 1.2 million enrollees come from Long Island.

The HIP half of the HIP/GHI combination is strong in this region, due to the company's 2001 acquisition of the Long Island HMO Vytra Health. Among its product offerings is SmartStart, an EPO with a $100,000 annual

[1] Robinson JC. November-December 2004. Consolidation and the transformation of competition in health insurance. *Health Affairs* 23(6): 11-24.

benefit limit, a $500,000 lifetime cap, and a limited hospital network. MDNY, the last of Long Island's regional health plans, ceased enrolling new members in 2007, and entered liquidation in 2008, an apparent casualty of the market shift to experience-rated HMO/POS product designs with high cost-sharing features.

Region 3:
Hudson Valley
Counties:
Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Under-65 population:
1.94 million

The Hudson Valley region is the arena where the New York City for-profit market players and strong nonprofit regional plans from the north meet. Two for-profit plans, Empire and Oxford/UnitedHealthcare, dominate, with a combined share of nearly 75 percent of the fully insured employer group market. Much of the Oxford/United enrollment is due to Oxford's strength in the region prior to its merger with United. Plans like Oxford (based in Trumbull, Connecticut) and Health Net (with a 5 percent market share) have always done a brisk cross-border business in the Hudson Valley; Aetna also maintains a 5 percent market share.

Two nonprofit health plans based just north of the region, MVP Healthcare and Capital District Physicians Health Plan (CDPHP), have established a strong presence in the region. MVP, with a nearly 10 percent market share, has built a strong relationship with an innovative Hudson Valley IPA, the Taconic Group, and administers benefits for many self-funded IBM employees. CDPHP has reached down from its Albany base to garner enrollment of over 13,000 group members.

Region 4:
Albany/Northeastern New York
Counties:
Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Under-65 population:
1.23 million

The Albany/Northeast New York region is perhaps the state's most well-balanced, with all three of the state's Blue Cross plans and for-profits like UnitedHealthcare competing with two major regional HMOs for state workers and employer groups in the region.

Albany-based CDPHP, with nearly $1 billion in revenues in 2006, was begun by physicians in 1984. After a start as an IPA-model HMO, CDPHP has expanded its product offerings through its Article 43 subsidiary to include PPO, EPO, and HDHP/HSA benefit plans. It also operates an ASO and owns a TPA, is an active participant in state public programs, enrolls many state workers headquartered in Albany, and does a vigorous Medicare Advantage business. Its service area has expanded to twenty-nine counties, running from the Canadian border in the north to the New York City suburban counties in the south and west as far as Tioga County in the Southern Tier, and includes seven counties in Vermont.

One county to the west, Schenectady-based MVP Healthcare is another strong regional IPA-model HMO. It differs from CDPHP due to its focus on employer groups rather than public program enrollment. MVP, which opened its doors in 1984 as the provider-sponsored Mohawk Valley Plan, has made some important strategic moves recently. The company's merger with Rochester-based Preferred Care in 2006 boosted its enrollment in state and federal public programs and opens a second front

in Rochester with central New York giant Excellus, with whom it also competes in the Syracuse and Southern Tier regions. MVP's service area now extends from Rochester all the way east through Vermont to New Hampshire, Massachusetts, and Connecticut, and south through central New York and the Southern Tier into Pennsylvania. The combined MVP/Preferred Care membership exceeds 700,000 members.

MVP aggressively markets its "TriVantage" line of products, which offer wellness programs, preventive care discounts, and bonuses to members. Billboards in the region tout the fact that the plan "Pays for Fun and Fitness – up to $600."

In 2006, MVP also announced a strategic alliance with Cigna that allows it to use Cigna's national network to court multistate employer groups and self-funded plans. The ability to offer a national network is widely viewed as key to a regional health plan's survival. Cigna entered into similar agreements with health plans in Massachusetts, Minnesota, and Michigan, and the deal also allows Cigna to access MVP's strong network for its enrollees.

Another distinguishing feature of the Albany region is the head-to-head competition in several counties of two Blue Cross plans, HealthNow, the Buffalo-based BCBS plan, and Empire. Due to their respective takeovers of two competing Albany-based Blue Cross and Blue Shield plans, HealthNow competes against Empire as Blue Shield of Northeastern New York in Albany and the northeast part of the region. Such "Blue vs. Blue" competition is very rare. Local Blue Cross plans are franchisees of the Blue Cross Blue Shield Association, the national trade group that sets rules for individual franchisees. Usually, their service areas do not overlap, and the plans are prohibited from competing against each other outside of their own service areas while using the BCBS trademarks, the cross and the shield, or the benefits of the trademark in advertising.

"Non-branded" competition, where one BCBS plan competes against another Blue plan outside its service area but cannot use the BCBS trademarks, is difficult, since the "invading" BCBS plan enters the fray without its strongest marketing tools. Horizon BCBS of New Jersey folded its unbranded plan in New York City in 2007, and HealthNow has had a difficult time as an unbranded competitor in Central New York.

A final note on Region 4: The administration of the Empire Plan and NYSHIP from Albany skews enrollment because some plans report their statewide enrollment through the Empire Plan as if all members worked in Albany; unadjusted, Region 4 enrollment in group insurance based on health plan annual statements exceeds the total under-65 population there. To provide a clearer picture of enrollment, we used NYSHIP reports to distribute Empire enrollment to areas of the state where members live. While this method is imperfect, it does produce regional enrollment figures that are better estimates of health plans' market positions in the respective regions. In the region, enrollment for Excellus and HIP is attributable to NYSHIP enrollment.

Region 5:
Syracuse/Central New York
Counties:
Broome, Cayuga, Chemung, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins
Under-65 population:
1.44 million

Entering Central New York is entering the Excellus zone, a fifteen-county region with many of upstate New York's smaller population centers — Binghamton, Syracuse, Utica, Ithaca, Auburn, and Watertown — that the

Rochester-based BCBS plan dominates, with nearly two-thirds of employer group enrollment. The remainder is split between CDPHP and MVP, the two regional HMOs just to the east, and HealthNow, the Buffalo-based BCBS plan that must compete on a non-branded basis in the region. Despite marketing efforts and investment, HealthNow has achieved only about a 10 percent market share in the region. Much of UnitedHealthcare and Empire enrollment is attributed to the state's Empire Plan.

Excellus built its market dominance in the region, which extends south to the Pennsylvania border, through its takeover of two Blue Cross plans in the region (Central New York and Utica/Watertown) and its acquisition of Univera HMOs in Syracuse and Binghamton. Excellus's merger with the two BCBS plans was encouraged by regulators; its acquisition of the other HMOs was clearly a strategic decision.

Central New York also begins New York State's nonprofit corridor, where for-profit plans like United and Aetna have yet to make significant enrollment inroads. The region's nonprofit BCBS plans vigorously defend their turf, market observers say, and for-profit plans have had difficulty signing up provider networks, particularly hospitals. Nonprofit health plans, meanwhile, noting the absence of the competitive pricing that usually signals a market share move, argue that companies like Aetna and United "aren't really trying" and have settled instead on a long-term strategy to quietly build enrollment by picking off medium-size employers and large self-funded groups. United recently signed an agreement to become an exclusive provider of a Healthy NY product through the Greater Syracuse Chamber of Commerce; it also maintains a presence as an employer in east Syracuse, and a large workforce in the Buffalo region.

Region 6:
Rochester Area
Counties:
Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
Under-65 population:
1.06 million.

Rochester, a special region in New York's health care history, is the headquarters for the nonprofit BCBS plan Excellus (formerly Rochester Blue Cross Blue Shield) and its corporate parent, Lifetime Healthcare Companies. With close to two million self-funded and fully insured members, it is the largest of the upstate health plans: it has more than twice the enrollment of its closest upstate competitors, HealthNow and MVP/Preferred Care, and is the fourth largest health plan in the state.

Excellus operates in thirty-one counties in upstate New York through four regions: Utica, which stretches northeast to the Canadian border; two Central New York regions, Syracuse and the Southern Tier (along the Pennsylvania border); and Rochester. The company also operates in eight counties in Western New York, through Univera Healthcare, its unbranded subsidiary.

The organizational structure reflects Rochester BCBS mergers with independent BCBS plans in Syracuse and Utica-Watertown, and with Univera, which operated in Buffalo, the Southern Tier, and the Syracuse area. Each of the regional offices is managed with "advisory boards" composed of civic leaders and health care institutions. With more than 7,000 employees in thirty locations in upstate New York, Excellus is also a major upstate employer.

Excellus offers a full portfolio of products, including newer consumer-directed products such as Blue Healthy Choices and HealthyBlue. But its leading "vote-getter" is its PPO line, followed closely (and surprisingly) by indemnity products. The

company enters into a large number of "single-case" agreements, covering workers at large firms under special policy forms tailored to the needs of a particular group. One of its subsidiaries, Support Service Alliance, offers services to small businesses, including an experience-rated association group health plan. On the public side, Excellus's arrangement with the Monroe County Health Plan makes it a strong player in all public programs.

The Rochester region is the most highly concentrated region in the state, with enrollment centered in two health plans, and little change in overall enrollment from year to year. Playing David to Excellus's Goliath is Preferred Care (known as Rochester Area HMO, Inc., in regulatory filings). Established in 1979 to provide consumers and employer groups with an alternative to Rochester BCBS, Preferred Care merged with MVP Health Care in early 2006, is gradually integrating MVP products into its line of offerings, and in 2009 changed its "married name" to MVP Health Care. Preferred Care is active in state public programs, excels in group and individual Medicare Advantage products, and administers the large, self-funded program for Kodak employees. In an intriguing development in 2009, Excellus and Preferred Care — long-time antagonists — announced plans to jointly sponsor a medical home demonstration program, to test the model and see if it improves quality. By simultaneously agreeing to make greater investments in primary care, the plans in effect entered into a "bilateral disarmament agreement," difficult to duplicate in the New York City region, for example, but an example of some of the possibilities for reform in smaller, more concentrated markets upstate.

Aetna, still a minor player in terms of fully insured business, vaulted into the market in 2002 through an agreement with the University of Rochester to administer its new self-funded benefit plan, a decision that stunned a community still reeling from an earlier decision by Kodak to leave Rochester's "community pools" and self-fund its employee benefit program.[2]

Community rating wasn't invented in Rochester, but few communities embraced the use of large community pools to insure individuals, small groups, and large groups to the degree that it did, making it a cornerstone of the Rochester Model, which drew national attention and praise in the 1980s and early 1990s for its ability to cover more people at lower costs.[3] As a result, perhaps no region has felt the decline of the Large Group community-rated market as acutely as Rochester. Kodak's gradual move towards self-funding began in 1997, followed in short order by many of the largest employers in the community, such as Paychex (1999), Xerox (2001), the University of Rochester (2002), ViaHealth, and Unity Health Systems (2006).[4] Officials at Excellus estimate that community-rated enrollment has shrunk from 80 percent to 30 percent of its overall business in the last several years.

Region 7:
Buffalo Area
Counties:
Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming
Under-65 population:
1.26 million

If the Rochester region is a two-horse race, the Buffalo/Western New York region is a three-

2 Kodak opts for self-insurance. *Rochester Democrat and Chronicle*, September 22, 2001.

3 U.S. General Accounting Office. Rochester's community approach yields better access, lower costs. GAO-HRD-93-44. See also Leitman R, RJ Blendon, H Taylor, E Kramer, and D Klein. January-February 1993. Rochester, New York: A model for health reform. *Journal of American Health Policy* 3(1): 49-54; and Hall WJ and Griner PF. Spring 1993. Cost-effective health care: The Rochester experience. *Health Affairs* 12(2): 213-215.

4 Various articles 1995 to 2006. *Rochester Democrat and Chronicle.*

horse race; long-time competitors Independent Health Association and HealthNow, the Buffalo-based BCBS plan, split the non-public employee commercial market almost evenly, with limited enrollment at Excellus's non-branded subsidiary, Univera. A forty-year-old HMO that Excellus acquired as part of the Health Care Plan merger, Univera has boosted Excellus public program enrollment in the region in particular through a partnership with the plan and a local hospital.

Established in 1980, Independent Health Association (IHA) is another one of those regional, IPA-model HMOs that has survived. IHA's first and only enrollees, as one former official noted, "were the people who worked here when we opened the door." Company officials are proud of their high rankings in various quality reviews, and view themselves as more innovative and nimble than their cross-town Blue Cross competitor. The plan recently announced an expanded list of "zero co-pay" preventive services that would be integrated into all product lines, and has worked to redesign physician practices to improve primary care. Company officials report success with their "IDirect" HDHP series of products.

IHA operates through its HMO license and an Article 43 subsidiary, recently purchased a TPA for self-funded business, and features an ASO unit as well. Much of the company's growth and revenues of late have been from public programs, particularly Medicare Advantage. Another example of the statewide trend away from traditional HMO products, IHA has been migrating its managed care business to EPO products issued by its Article 43 subsidiary. A 1990s expansion into the Hudson Valley and the New York City region was abandoned several years ago; the company focuses on its eight-county region in Western New York. At one time, IHA provided management services for Albany-based CDPHP, and the two health plans jointly established a reinsurer and an Article 43 health plan, but those relationships have ended.

From its spanking new "green" headquarters on a brownfield site in downtown Buffalo, HealthNow New York operates as the Blue Cross licensee in the region (BlueCross BlueShield of Western New York), and presses the advantages of "being Blue." But the company also competes head-to-head with sister Blue Cross plans Excellus, as "unbranded" HealthNow in Central New York, and against Empire in the Albany region through its Blue Shield of Northeastern New York division. HealthNow offers a range of indemnity, PPO, and EPO products, as well as HMO public and private offerings through its Community Blue and HealthNow HMO lines. All told, the company estimated enrollment of over 815,000 members in fully insured, self-funded, and public programs in thirty-eight counties.

The company's board authorized the exploration of conversion to for-profit status in 2002, but is now refocused on its nonprofit mission. Company officials count as key strengths their strong enrollment among city and county employees, and teacher and other unions.

Like those in the Rochester and Central New York regions, Western New York health plans and consumers are grappling with the disappearance of Large Group community-rated business. Smaller employer groups with less favorable claims experience are absorbing higher rate increases as healthier large groups opt out. HealthNow seeks to derive some benefit from the trend by coaxing its Large Group community-rated customers to "go all Blue" — enroll all their workers in a variety of experience-rated BCBS plans.

Appendix C: Why Are New York's Individual Market Benefits So Comprehensive?

Like most landmarks in New York's recent health care history, the enactment of the 1995 Point of Service Law that dictated benefits for the individual market was shaped by ongoing financial problems at Empire BlueCross.

Despite the enactment of the Community Rating/Open Enrollment Law in 1992, Empire still insured a disproportionate share of high-risk individuals through two old-fashioned indemnity products, TraditionPlus Comprehensive and TraditionPlus Wrap-around. While the CR/OE law required HMOs to join Empire in accepting all applicants in the individual market, most enrollees stayed put due to differences in the benefit packages. HMOs simply did not offer individuals policies that covered prescription drug benefits.

The combination of continuing losses in its community-rated business and the poor performance of its experience-rated and self-funded national accounts contributed to a brewing "Empire crisis" in 1994. Still weary from the convulsive implementation of the CR/OE law in 1992 and 1993, state policymakers and state regulators were again forced to confront the problems of dwindling reserves at Empire, and consumer outrage at large rate increase requests.

Despite a nearly $100 million cash infusion from special legislation in January 1993, Empire officials came back, in November 1994, seeking increases of as high as 42 percent for its over 700,000 community-rated customers. That number included about 85,000 TraditionPlus individual customers, whom company officials said would generate $100 million in losses for 1994 — producing a 147 percent loss ratio — due to claims experience two and three times more costly than that of individuals insured through large groups.[1] Company officials spoke publicly of the possibility that it would stop offering the TraditionPlus products to individuals, exacerbating anxieties among consumers who faced a market in which a drug benefit might not be available at any cost.

With Empire's reserves hovering around $200 million on $5 billion in premiums, the Blue Cross Blue Shield Association added a new wrinkle: stung by liabilities from the recent insolvency of a Blue Cross plan in West Virginia, the Association announced that it would pull the BCBS trademark from Empire unless Empire improved its reserves, and that it had made contingency plans to take over Empire's business as one of the state's Medicare administrators.[2]

For New York's newly elected Pataki Administration, it was a quick lesson in what dealing with Empire entailed. No matter the level of frustration or dissatisfaction with Empire's management, state regulators had to keep in mind the millions of subscribers who relied on the plan for coverage, including hundreds of thousands of vulnerable senior citizens and Direct Pay customers; hospitals that relied on the cash flow from the upfront payments Empire made under the state's rate-setting system; and the chaos that would result from the insolvency of the state's largest health insurer. As Greater New York Hospital Association President Kenneth Raske noted at the time, the company's problems had sent

1 Empire rate increase narrative summary. November 1994.

2 Crisis looms as big insurer keeps sliding. *New York Times*, August 28, 1994.

"shivers through the hospital community.… If they hit a rock, we hit a rock."[3]

But while the State Insurance Department grappled with the pending rate increase request from Empire, a new plan was percolating to deal with the problem. The state's HMO trade association had proposed a program under which their downstate members would offer a new managed care plan with comprehensive benefits that included drug coverage, as well as an out-of-network benefit based on the increasingly popular POS products HMOs had begun offering to their group customers. Some observers believed that the costs of Empire's high-risk customers could only be controlled by introducing a managed care model. As the 1995 legislative session began, key lawmakers in the Assembly drafted and passed a bill based on the HMO plan. When, in March 1995, the Insurance Department approved a scaled-back rate increase request for Empire that still meant annual premiums of nearly $14,000 for comprehensive coverage, calls on the Pataki Administration to join the effort grew louder.[4]

The end product (Chapter 504 of the Laws of 1995) required HMOs to offer two new managed care products to individuals, one with out-of-network coverage, with benefits modeled on Empire's TraditionPlus packages. Benefits were clearly defined in statute,[5] right down to the levels of co-pays permitted, and the Insurance Superintendent was authorized to promulgate new benefit packages by regulation. In return for their new obligations, the state's HMOs won significant concessions: the elimination of the Insurance Department's prior approval authority over health plan rates, and the gradual replacement of a risk adjustment mechanism based on demographic characteristics of those insured by a health plan — which HMOs believed penalized them for their younger customers' acceptance of managed care — with a system based on specified medical conditions.

The new law was not without its critics. HMOs argued that including benefits for extensive home care visits and skilled nursing facility coverage would lead to adverse selection. And health plans in regions such as Rochester viewed it as a step backward, since many still pooled individuals with Small- and Large Group members. Today, critics of the market are incredulous that New York adopted both community rating and a quality benefit package without an individual mandate, and banned less generous benefits for those who wanted to purchase or could only afford more-limited coverage.

Given the imperatives policymakers faced at the time, however — no options for high-need medical consumers besides Empire or "spending down" to qualify for the state Medicaid program; the life-and-death possibility of an individual market without drug benefits; sky-high annual premium increases for individuals; dwindling reserves and significant losses at Empire, and the prospect of insolvency or loss of the company "mark" — the measure proved very successful. In short order, the population whose medical treatment was draining Empire's reserves was redistributed to other health plans, and consumers gained significant new options for quality, comprehensive benefits at more affordable rates. The ability of consumers with chronic illnesses to maintain access to trusted specialists by purchasing the POS product was crucial.

Nearly 70,000 individuals — including more than 6,000 who were previously uninsured — had purchased the new

3 Ibid.

4 Empire granted 15% rise in premiums for 727,000. *New York Times*, March 3, 1995; and Rate hike big Cross to bear. *New York Daily News*, March 3, 1995.

5 NYIL Sections 4321 and 4322.

products, according to a 1996 report.[6] Rates for the new HMO products were 30 percent to 50 percent lower than for TraditionPlus products. A New York City family, for example could purchase the POS policy for $854 a month, compared to $1,264 a month for Empire's TraditionPlus; individual buyers in Albany could shave $50 to $200 a month off their premiums.

Enrollment in the standardized HMO products crested at 113,000 in July 1999, however, and has been declining since, particularly of late. The two health plans with the largest number of Direct Pay subscribers earn healthy profits on the business with file-and-use rates, but with their small pools of customers, upstate health plans don't fare as well, and the products are unaffordable to the majority of consumers across the state. State stop-loss subsidies have been reduced, rather than increased to keep up with health care inflation and the deteriorating risk profile of enrollees.

6 Muhl E [New York State Insurance Superintendent] and the Chapter 504 Technical Advisory Committee. October 1, 1996. The impact of the standardized direct payment enrollee contracts offered pursuant to Sections 4321 and 4322 of the Insurance Law on the individual health insurance market.

Appendix D: "Reg. 62": Pioneering Regulation

Much of the key regulatory framework for health plans today grew out of a far-reaching and creative series of regulations issued by the State Insurance Department in the early 1970s, during the Rockefeller Administration, under former Insurance Superintendent Benjamin R. Schenck. Although amended many times since then, 11 NYCRR Part 52, or Regulation 62, remains far-reaching in its scope and everyday importance to insurance markets, including in several areas that are hot topics among policymakers today: complex benefit designs and cost-sharing, minimum loss ratios, and consumer disclosure.

Reg. 62 followed the enactment of the Health Insurance Consumer Protection Act, legislation proposed by Governor Rockefeller and enacted by the legislature in 1971. The modest law,[1] only six paragraphs long, charged the Insurance Department with promulgating "Minimum Standards for Form, Content and Sale of Health Insurance, Including Standards of Full and Fair Disclosure." The legislation came against a backdrop of state and federal universal coverage proposals, growing concern about health care inflation, and unease with the growth of commercial insurers selling consumers coverage of questionable value through print and TV ads and direct mail campaigns.[2]

The statute directed the Department to craft the minimum standards to achieve five specific goals. As stated in Chapter 554 of the Laws of 1971, Insurance Law Section 3217, these are:

- "Reasonable standardization and simplification of coverages to facilitate understanding and comparisons;
- elimination of provisions which may be misleading or unreasonably confusing, in connection either with the purposes of such policies or contracts or with the settlement of claims;
- elimination of deceptive practices in connection with the sale of such policies or contracts;
- elimination of provisions which may be contrary to the health care needs of the public; and
- elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders."

In the first series of resulting regulations, the Department moved quickly, in March 1972, to ban so-called "dread disease" insurance, the impetus for the introduction of the original legislation. State officials believed that marketers of these products — which covered treatment related to cancer or heart disease — preyed on peoples' fears to make their sales, which resulted in high profits for insurers but low benefits paid out to policyholders.[3] The prohibition on the policies stood for almost twenty-five years, until a 1997 regulation issued by the Pataki Administration permitted the policies if bought in conjunction with other health insurance, and coverage was limited to no more than eight diseases.[4]

The preamble to the regulation carries surprising relevance to today's insurance market:

1 Chapter 554 of the Laws of 1971; NYIL Section 3217.

2 Lyons RD. February 27, 1972. State and federal officials intensify scrutiny of commercial health insurance. *New York Times*.

3 "Dread disease" insurance bar to go into effect here on May 1. *New York Times*, March 13, 1972.

4 22nd Amendment to Regulation 62, 11 NYCRR 52.15. March 31, 1998. For additional background see Dao J. March 24, 1997. Seeing an opening, an insurer lobbies Albany to lift a ban. *New York Times*.

> "The insurance industry should be encouraged to provide new forms of coverage and new ways of reducing health care costs. But innovations should provide health care benefits of real economic value. Health insurance policies designed merely to produce superficial difference or play upon people's fear of particular disease, and insurance policies which are unduly complex or unduly limited, do not meaningfully expand consumer choice, but instead serve to confuse and make intelligent choice more difficult. Those coverages which are of no substantial economic benefit or are contrary to the health care needs of the public, or contain provisions which serve only to confuse or obfuscate, are prohibited by this Part."

The initial regulation also represented an early and ongoing effort to curb medical underwriting. Provisions were adopted in the regulation to sharply limit policy exclusions based on an insured's illness or treatment received. Only exclusions contained in the regulation were permitted. But tellingly, the list of permitted exclusions included both pregnancies and "mental or emotional disorders, alcoholism and drug addiction," which state officials believed would involve "major cost implication of 25 to 50 per cent costlier premiums if they were mandated as part of comprehensive health-care policies."[5]

Its major goal accomplished with the elimination of dread disease insurance, the Department went on to issue three more series of sweeping regulations in the next year. Following a process of proposing regulations and then convening public hearings for comment, the Department initially adopted regulations "designed to improve disclosure of health insurance coverages to the public." A pioneering effort to standardize benefits, those regs first established categories of health coverage — "basic hospital," "basic medical," and "major medical" — and then set minimum benefit standards in each category, which insurers had to meet in order to market the coverage.

A second series of regulations set rules and procedures for the preparation and submission of policy forms and riders for health insurance policies, many of which apply today. The final regulations set limits on experience rating for group policies, and established minimum loss ratios — ranging from 40 percent to 65 percent and also largely still in effect today — for all accident and health insurance policies.[6]

Predictably, the regulations drew a mixed response from the various camps, as industry groups claimed the Department went too far and consumer groups countered "not far enough." In a 2,000-word critique of an early draft of the regulations, the Citizens Committee for Children of New York characterized the regulations as "another hoax on consumers," described the minimum loss ratios as wasteful and too generous for insurers, and called for the elimination of all experience rating, because "to tie the cost of access to the health care system to the accident of one's employment situation is unfair and inequitable, and presents a barrier to the health system for persons most in need."[7]

At hearings on later drafts of the regulation, New York City Consumer Affairs Commissioner Bess Myerson (in testimony delivered by her deputy, future City Council Member and Parks Commissioner Henry J. Stern), said the regulation had enough loopholes in it to "run an ambulance through." An industry spokesman said the ban on dread disease policies would "prevent freedom of choice," and counseled state policymakers to focus on "bringing the delivery and costs of

5 *New York Times* 1972. [Note 3]

6 11 NYCRR 52.45.

7 Health insurance protection act found deficient by civic group. *New York Times*, November 15, 1971.

medical services under control while awaiting action on Federal action on a national health insurance plan."[8]

For its part, the Department recognized, in the instance of medical loss ratios, for example, "that generally speaking, the consumer is better served by policies which produce high loss ratios." But the regulations charted a middle course:

"The establishment of *minimum* loss ratios [emphasis in original], coupled with disclosure of loss ratios to consumers, provides for the continued availability of most existing policies, for now, and establishes effective machinery through which insurance values can be increased, in the long run, by the operation of consumer choices."[9]

8 Faults are cited in insurance act; proposal to aid consumers scored by Bess Myerson. *New York Times*, January 27, 1972.

9 Schenck BR. April 2, 1973. In the matter of amendments to Regulation 62 (Health Insurance). [Decision by Superintendent of Insurance]

Appendix E: The Last of the "Pure" States: New York's Community Rating/Open Enrollment Law Turns 15

Oft-reviled in conservative quarters,[1] New York's Community Rating/Open Enrollment law turned fifteen years old in 2008. While changes in 1995 added standardized benefits for individuals and a mandate that HMOs offer coverage to individuals, the law's core components are essentially unchanged since its passage in 1992. Serious challenges to the law have come not from New York State lawmakers but from federal reform proposals such as the Health Insurance Market Modernization and Affordability Act[2] and related federal "association health plan" legislation that would have preempted state regulation of insurance markets.

The law adopted in 1992 was comprehensive. It not only required that all health plans community rate their individual and Small Group business (as most Blue Cross and HMO plans were already doing in an estimated 70 percent of the market), but also instituted new limitations on insurers' ability to exclude coverage (pre-existing condition reforms), guaranteed individuals and small groups the right to purchase a policy (open enrollment) and renew it regardless of claims experience (guaranteed renewability), and allowed individuals and small groups to switch plans without undergoing new waiting periods (portability). Passage of the law came after one of the most tumultuous years in New York's modern political history.

Sometimes evaluated as a universal coverage initiative, the intent of the CR/OE law was more modest. An approval memorandum issued in conjunction with the signing of the bill termed it "one of the most significant initiatives that the State has undertaken for its elderly, its sick and all those who, with the passage of time, will become elderly or sick,"[3] but noted that the legislation was "not the total answer to the health care crisis faced by the state" but instead a "worthwhile beginning," and that "true reform must start in Washington."

Goals of the legislation are clearly stated in its preamble and implementing regulations:

"(1) To facilitate access to health insurance by all New York residents who wish to obtain it directly or as members of small groups; and

(2) To promote competition among insurers and health maintenance organizations on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs; rather than on the basis of differing underwriting and rating practices which allowed some insurers to exclude higher risk applicants from coverage and cause unaffordable premium rates to those unable to meet selection standards."[4]

In a letter defending the legislation a year after its implementation, Governor Cuomo summarized it this way:

"Community Rating and Open Enrollment addresses a critical flaw of our health care system by eliminating discrimination and challenging insurers to manage risk and not run from it. Its effectiveness will be enhanced by universal coverage, but its value is fundamental to public policies — discrimination due to age, sex or illness should not be tolerated. Community rating views the setting of insurance premiums as if all persons are

1 Graham JR [editor]. July 20, 2006. What states can do to reform health care: A free market primer. San Francisco: Pacific Research Institute.

2 S.1955-Enzi [Health Insurance Marketplace Modernization Act (HIMMA)]. 2006.

3 Approval Memorandum No. 25, Chapter 501 of the Laws of 1992.

4 11 NYCRR Part 360, known as Regulation 145.

part of a family — each sharing in the overall costs in order to weather the unpredictability of life. Thus some will pay more to offset the burdens of others, knowing someday we will all need help."[5]

One observer aptly characterized the debate as the conflict between two visions of fairness: a "social solidarity" vision of health insurance markets, and "actuarial fairness," in which risk is carefully analyzed, segregated, and priced accordingly.[6]

The Blues vs. the Commercials

While the desire to right the wrongs perceived in health plan underwriting was at the forefront, the factors and motives that led to the bill's passage after a six-month bare-knuckled legislative brawl were complex and manifold. The simple shorthand staffers developed for the decision facing the legislature — to "make the Blues like the commercials or the commercials like the Blues" — belied the complex policy and political issues lawmakers and regulators faced. The real prospect of an insolvency at Empire Blue Cross lent tremendous urgency to the debate; a key strategic decision by state regulators to tie passage of the bill to future rate increases for Empire subscribers put legislators who might otherwise have opposed the bill in a real vise.

As was the case in other states that adopted individual and Small Group reforms at the time,[7] Empire — with 10.5 million customers the state's largest insurer — was in trouble. The company had watched its losses mount in its individual business, the steady migration of its Small Group customers to commercial insurers (400,000 from 1988 to 1990 alone),[8] and steadily declining reserves. Rate increases of 14 percent in 1990 and 19 percent in 1991 generated public outrage but failed to stem its hemorrhaging reserves, which had dwindled to just $295 million at year-end 1990.[9]

State regulators attributed at least some of Empire's financial problems to disturbing signs of the implosion of a bifurcated insurance system in which commercial insurers used underwriting to recruit Empire's better customers, and dumped their costly insured on Empire. The carefully crafted informal agreement for the market — Empire would use competitive advantages stemming from the state's hospital rate-setting system to subsidize high-risk customers — seemed unsustainable, and increasingly aggressive commercial underwriting practices drew concern. "They were experience-rating groups of ten and fifteen," one former state regulator recalls. Empire's solvency, at the same time that a major life insurer, Executive Life, had become insolvent, was at the forefront of the Insurance Department's concerns.

State Medicaid officials shared insurance regulators' fears of an Empire insolvency. Empire's failure could mean that the state Medicaid program — already reeling from cuts — would replace Empire as the "insurer of last resort" for hundreds of thousands of enrollees with medical conditions that made them "uninsurable" with commercial plans.

In the boom and bust cycle that began shortly after Empire's creation and characterized its complicated relationship with state regulators,[10] Empire again went before state regulators, in July 1991, with a bombshell to drop: not only would it seek another sharp rate increase, but it would

5 Cuomo MM [Governor]. July 28, 1994. Letter to the editor, *Washington Post*.

6 Stone D. Summer 1993. The struggle for the soul of health insurance. *Journal of Health Politics, Policy and Law* 18(2): 287-317.

7 Nichols LM. February 2000. State regulation: What have we learned so far? *Journal of Health Politics, Policy and Law* 25(1): 175-196.

8 Health insurer plans to seek big rate rise. *New York Times*, July 25, 1991.

9 Blue Cross asks 26% rise for some customers. *New York Times*, January 17, 1992.

10 Marmor TR. Winter 1991. New York's Blue Cross and Blue Shield, 1934-1990: The complicated politics of nonprofit regulation. *Journal of Health Politics, Policy and Law* 16(4): 761-792.

also split its individual and Small Group customers into high- and low-risk categories, upping rates by as much as 50 percent for over 400,000 high-risk customers.

The proposed retrenchment from its commitment to community rating — while embraced by many other Blue Cross plans nationally — caused a firestorm in New York and galvanized consumers. Once largely the province of senior citizens protesting Medigap rate increases, the State Insurance Department public hearing this time, on Empire's new rate plan, was a barn burner. Senior citizens joined gay activists on picket lines in front of the hearing hall, and what later became known as "the illness groups" — nonprofit organizations gathered under the new umbrella of New Yorkers for Accessible Health Coverage, to advocate for people with chronic illnesses such as MS, cancer, and hemophilia — turned out in force to testify at the hearing.

As New York confronted the growing public health crisis of HIV infection, highly motivated AIDS advocacy groups such as Gay Men's Health Crisis (GMHC) and AIDS Coalition to Unleash Power (ACT UP) joined the coalition, bringing more militant tactics and an edgy energy to the fray. Protestors at the hearing unfurled a giant sign saying "Discrimination Kills People with AIDS." Facing the testifying Empire officials, a street theater group, the "Faceless Bureaucrats," wore signs bearing the Empire logo and officials' names and salaries, and wore paper-plate faces stamped with the slogan "Empire — We Don't Care, We Don't Have To."[11]

State officials rejected the entire proposal out of hand, and promised a more comprehensive solution. When, the following January, Empire applied for another rate increase for 1.2 million Small Group and individual customers, Insurance Superintendent Curiale hit on a new strategy to move the community rating/open enrollment legislation proposed by the Cuomo Administration the year before, but largely ignored: unless the Legislature approved the bill by April 1, 1992, the rate increase would be granted.

Two camps were joined. Assembly Democrats lined up with the Cuomo Administration; groups like the New Yorkers for Accessible Health Coverage coalition, represented by a small lobbying firm specializing in nonprofit clients, Act-Up, and GMHC provided the ground troops; and lobbyists from the Albany law firm that represented the state's Blue Cross plans prowled the halls of the Capitol tirelessly talking up the bill. On the other side, Senate Republicans, traditionally more receptive to the insurance industry, lined up with national and New York-based commercial insurance trade groups such as the Life Insurance Council of New York and the Health Insurance Association of America; lobbyists for a handful of commercial health insurers, including MetLife, Prudential, The Guardian, Chubb Life, and Mutual of Omaha; insurance agents' groups; and some small business interests.

At the outset, the commercials and their allies painted Empire's financial troubles as the byproduct of poor management (particularly of Large Group accounts), warned of the stiff rate increase younger, healthier customers would face, and threatened to pull their products — and jobs — from the state if the bill were to pass.

Meanwhile, supporters of the bill railed against commercial insurers' underwriting practices, papering legislative offices with details about occupational groups that the insurers "blacklisted" (including landscapers, construction workers, police and fire fighters, hairdressers, and florists), and the impact of commercial insurers' rating practices on women and older New Yorkers. With careful

11 Timour K [interviewee]. April 5, 2003. ACT UP Oral History Project.

use of language and a relentless barrage of newspaper articles and background pieces about commercial insurers' "discriminatory" practices, the bill's proponents changed the debate from a discussion about assessing and pricing risk to a virtual civil rights showdown. As the months wore on, legislators' offices were flooded with tens of thousands of postcards, preprinted but hand-signed, from Empire subscribers, generated through a direct mail campaign organized by a veteran political campaign consultant. Consumer group activists worked to magnify their presence by leafleting suburban shopping malls and train stations, targeting downstate districts represented by Senate Republicans.

When the Assembly approved the legislation, sponsored by Insurance Committee Chair Pete Grannis, by the April 1 deadline, Superintendent Curiale granted a portion of the increase Empire sought and warned that more would follow unless the state Senate acted on the bill in its chamber. Governor Cuomo equated the Senate's failure to act with "voting for a tax increase on Blue Cross subscribers," and continued, "Tax increases are the bane of a politician's existence. Well, they just voted for them." Senate Insurance Chairman Guy Velella, who with Senate Health Committee Chairman Michael Tully led negotiations for the Senate, complained Cuomo was employing "political blackmail."[12]

In the following months, Senate Republicans continued to float a range of alternative proposals that restricted or moderated the most unsavory commercial insurer practices (banning cancellations of Small Group policies due to claims experience, eliminating commercials' ability to reject members of a group for coverage, limiting rate differentials based on age, sex, occupation, and claims experience),[13] and proposed a new high-risk pool for individuals rejected for coverage.[14] But again the proposals failed to gain traction; consumer groups vociferously rejected the establishment of a high-risk pool, and Blue Cross plans painted it as a "tax increase."

Advocates on both sides stepped up the heat — and the rhetoric. An insurer-sponsored group, New York Citizens for Health Care, bused an insurer's employees to Albany and staged a march down a street in front of the Capital; the group also issued a running series of memos with the boldface heading, "Why Does Blue Cross Lie?" Proponents, in turn, vowed that "the sick and aging will never be treated as lepers in a system where community rating and true open enrollment is the rule."

In the waning days of the session "everything just seemed to come together," says a former Cuomo Administration official. With Assembly Insurance Committee Chairman Pete Grannis warning in a floor debate that "this is the only thing that will prevent a rate increase due to go into effect for 1,200,000 Empire Blue Cross Blue Shield subscribers in the downstate region," the Assembly approved the measure for the second time. A few days later, the state Senate, unwilling to face the political consequences of being held responsible for the rate increase and appearing to side with insurers and against senior citizen supporters of the bill, followed suit.

As it scrambled to implement the complex legislation, Cuomo Administration officials had to contend with a tumultuous two years. A senior Empire executive was convicted of perjury before a U.S. Senate committee investigating Blue Cross plans nationally. While most subscribers saw their rates increase nominally or decrease, the impact

12 The insurance challenge: By granting rate increase, aides to Cuomo put Senate Republican leaders on the spot. *New York Times*, April 3, 1992.

13 S.8272 of 1992.

14 S.8273 of 1992.

on rates for young subscribers was significant — as much as 170 percent. Some health plans withdrew from New York's market as a result of the change, but the predicted mass exodus did not occur.

Perhaps the most difficult challenge to the law came against the backdrop of federal health insurance reform discussions. Commercial insurers issued a damning study in August 1994, claiming that individual and Small Group enrollment had dropped by over 500,000 in the year following the adoption of the reforms.[15]

A month later, New York's State Insurance Department challenged both the report's conclusions and its methodology, pointing out, for example, that the authors had used Current Population Survey data to develop their estimates of pre-reform enrollment, but used policy counts from individual insurers to develop their post-reform count.[16] The insurers' report was typical of early evaluations of the law, focusing on enrollment and morbidity figures that other critics of it also found flawed.[17] But despite those appraisals, considerable damage had been done, with the 500,000 figure circulated widely in the national media. Then-U.S. Representative Dick Armey, of Texas, during an appearance on the McNeil-Lehrer NewsHour, took it to a new level by asserting, unchallenged, that "New York State passes some insurance reform, results in 500 people — 500 million people dropping their insurance," as another critic of the study reported.[18]

More recent analyses found mixed and more measured impacts; "tradeoff" is the term that almost invariably crops up. In an exhaustive review of analyses of the legislation's impact on Small Group reforms, one researcher found that "Small Group reforms have not caused havoc in the market for small-firm health insurance, but neither have these laws brought about a quantifiable benefit."[19] Others came to similar conclusions, finding that, in one sense, the law "worked" because it made high-risk people relatively more likely to obtain coverage and pay lower premiums, without "overly large adverse consequences" on the markets as a whole — but with *some* loss of enrollment of low-risk people. The key question for policymakers, these authors argue, is "the extent to which an increase in coverage for high-risk people is worth a slightly larger corresponding decrease in coverage for low-risk people."[20]

Another analyst found that the law had failed in its immediate goals because it failed to stem huge losses at Empire, and the "combination of individual and Small Group reforms had failed to expand coverage or reduce costs," achieving only "more limited goals" by preserving access for high-risk individuals.[21]

Small Group Impact

The impact of the law is best viewed by separating out the Direct Pay and Small Group markets. For the Small Group

15 *The impact of guaranteed issue and community rating in the State of New York.* August 18, 1994. Milliman & Robertson, Inc.

16 Curiale SR [New York State superintendent of insurance]. September 15, 1994. Letter to Daniel J. McCarthy, Milliman & Robertson, Inc.

17 Buchmueller TC. 2004. What can we learn from the research on small-group health insurance reform? In *State health insurance market reform: Toward inclusive and sustainable markets* (Monheit AC and Cantor JC, eds.). London and New York: Routledge (International Studies in Health Economics series).

18 Lieberman T. January-February 1995. This is the story of the vested interest that hired the firm that fronted the study that skewed the numbers that spread through the press and finished off a vital piece of health care reform. *Columbia Journalism Review*.

19 Simon KI. 2004. What have we learned from research on small-group insurance reforms? In *State health insurance market reform: Toward inclusive and sustainable markets* (Monheit AC and Cantor JC, eds.). London and New York: Routledge (International Studies in Health Economics series).

20 Herring B. August 2006. The effect of state community rating regulations on premiums and coverage in the individual health insurance market. National Bureau of Economic Research Working Paper 12504.

21 Hall MA. February 2000. An evaluation of New York's reform law. *Journal of Health Politics, Policy and Law* 25(1): 71-99.

segment, those arguing for revisions to the law cite increased costs overall, less attractive rates for employer groups with younger employees, and the lack of incentives for members of employer groups to maintain healthy lifestyles.

Since HIPAA essentially ratified for the nation New York's decision to require guaranteed-issue, guaranteed-renewable Small Group policies, the effect of the community rating law is distributional, rather than a cost add-on. Since all employers are permitted to enter the small group market, New York's community rating law distributes the cost of coverage equally among all small groups, replacing a system with the same costs but that created winners and losers, depending on a group's risk profile. The argument to use Small Group claims experience to provide incentives for adopting healthier lifestyles seems problematic for a number of reasons. First, experience-rating formulas do not distinguish between claims related to unhealthy lifestyles and those related to other causes. Second, most health plans place little "credibility" in claims experience when prices are set for larger employer groups of up to 100 employees, relying instead on demographic factors or a blend of these factors or experience. Third, employer groups and health plans have a wide array of other tools to promote healthier lifestyles.

A more intriguing question is whether authorizing age rating in the Small Group market, as other states do, would promote increased small-group coverage, or would be "a wash" as new pricing causes some new enrollment and some disenrollment. Employer-sponsored insurance involves two transactions — decisions by employer groups to offer coverage, and decisions by employees to take up that coverage. A different rate methodology would apply regardless of individual firms' incomes. And precious few employer groups base employee contributions for health insurance on workers' incomes.[22] Further, while age rating enthusiasts invoke small businesses with concentrations of young workers as the chief beneficiaries, a review of census data suggests the picture is not so clear.

As the accompanying table shows, lower incomes are fairly evenly distributed among age groups after the age of twenty-five. While higher proportions of older workers have higher incomes, low-income status doesn't vary as much with age as one might expect.

While the prototypical firm with mostly young and low-income males would certainly get a better deal in states that allow age and sex rating, New York's CR/OE law does provide some benefits that are worth noting, several with particular relevance to what we know about employer-group offer rates in New York. In ways that do not receive much attention, New York's CR/OE law is pro-small business.

Stability. While New York's small businesses are reeling from double-digit rate increases, those increases don't vary from firm to firm based on each employer group's claims experience or the age and sex of its workers. Individual businesses' demographics and claims experience are pooled with those of other employers in the region buying similar products. In a sense, the structure mirrors features in experience-rated coverage for large groups, under which poorer-than-average claims experience is mitigated through pooling charges or stop-loss provisions that smooth out peaks. In contrast, many state rating schemes for small groups allow health plans to vary rates based on demographic factors, or to tack special surcharges of at least 15 percent on top of normal trend increases for renewals, based on "health status." A November 2008 *Wall Street Journal* article highlighted a Florida small business whose premiums rose 75

22 Gabel JR, JD Pickreign, HH Whitmore, and C Schoen. July-August 2001. Embraceable you: How employers influence health plan enrollment. *Health Affairs* 20(4): 196-208.

New York State Nonelderly Adults, 19-64, by Age and Health Insurance Unit (HIU) Income, 2005-2006

Age	Total		<200% FPL	200-299% FPL	300-399% FPL	400-599% FPL	600% + FPL
	Number of Adults in Age Group by Income *(thousands)*	Percent of Adult Population in Age Group	Percent of Adults within Income Group	Percent of Adults within Income Group	Percent of Adults within Income Group	Percent of Adults within Income Group	Percent of Adults within Income Group
19-24	1,600	13.6%	56.8%	12.3%	10.9%	9.1%	10.9%
25-29	1,250	10.7%	41.9%	16.9%	13.1%	17.6%	10.5%
30-34	1,200	10.2%	32.8%	15.6%	13.7%	19.2%	18.8%
35-39	1,400	11.9%	31.6%	16.6%	15.0%	17.4%	19.3%
40-44	1,450	12.4%	30.4%	13.6%	14.7%	19.8%	21.5%
45-49	1,480	12.6%	26.0%	14.3%	14.3%	20.0%	25.3%
50-54	1,310	11.1%	25.5%	11.9%	11.4%	18.4%	32.9%
55-59	1,150	9.8%	23.3%	12.3%	11.7%	19.7%	32.9%
60-64	900	7.6%	28.3%	15.4%	11.9%	18.5%	25.9%
Total	11,740,000	100.0%	33.7%	14.3%	13.0%	17.5%	21.5%

Source: Urban Institute, 2008. Based on data from the 2006 and 2007 ASEC Supplement to the Current Population Survey.

Age	Total		<200% FPL	200-299% FPL	300-399% FPL	400-599% FPL	600% + FPL
	Total	Share by Age	Share by Age	Share by Age	Share by Age	Share by Age	Share by Age
19-24	1,600	14%	23%	12%	11%	7%	7%
25-29	1,250	11%	13%	13%	11%	11%	5%
30-34	1,200	10%	10%	11%	11%	11%	9%
35-39	1,400	12%	11%	14%	14%	12%	11%
40-44	1,450	12%	11%	12%	14%	14%	12%
45-49	1,480	13%	10%	13%	14%	14%	15%
50-54	1,310	11%	8%	9%	10%	12%	17%
55-59	1,150	10%	7%	8%	9%	11%	15%
60-64	900	8%	6%	8%	7%	8%	9%
Total	11,740,000	100%	3,950,000	1,670,000	1,530,000	2,060,000	2,530,000

percent due to "the hiring of a few older workers by the 25-employee firm, pushing it into a higher-cost actuarial bracket."[23]

Claims experience can also cause unexpected jumps in rates in states that allow health status to be used. If the "trend plus 15 percent" system were in place in New York in the early 2000s, for example, rate increases of 10 to 15 percent would have turned into increases of 25 to 35 percent for some groups, sometimes in consecutive years. The trend-plus scheme also has the effect of limiting a small employer's ability to switch carriers: some schemes, as in Arizona, allow rates to vary by 60 percent for new business, or, as in Texas, up to 25 percent within each rating class.[24]

Industry. Many states also permit rate surcharges based on industry codes, a practice outlawed in New York for small groups. Although the rules increase rates for lower-risk businesses such as banking and computer programming, they produce lower rates for many small businesses that score poorly on industry factor underwriting and are associated with lower wages and low rates of employer-sponsored coverage — wholesale and retail, the arts, restaurants, hotels, bars and other service industries, agriculture, and construction, to name a few.[25]

Small Employer Groups. Many states also permit size-based additional surcharges for small employer groups. Massachusetts, for example, permits a 15 percent surcharge for groups of fewer than ten, and Connecticut permits a 25 percent group-size surcharge. New York's exclusion of group-size surcharges makes coverage more affordable for those smaller groups that, again, have significantly lower rates of employer-sponsored insurance.[26] In a tightly packed nine-state region made up of the northeastern and mid-Atlantic states, New York had the lowest premiums for groups of under ten in 2008.[27] Finally, as one veteran of the CR/OE effort noted, community rating "forced everyone to stop quibbling about what their share of the costs is, and to start thinking about why it costs so much and what to do about it. It wasn't a solution for rate increases, but it stopped all the quibbling about shares, and individual players lowering their shares by fragmenting markets."

The Direct Pay Market

In the Direct Pay market, the prediction that "the individual market will become essentially a widely dispersed high-risk pool funded by HMOs and Blue Cross plans, in which enrollment will continue to shrink and rates will continue to rise faster than inflation"[28] has come to pass. Enrollment in the standardized products created in 1995 declined sharply from over 100,000 in 2000 to just over 45,000 in 2007. As one observer noted, "Social solidarity also implies political support for public subsidies and other measures (e.g., mandates) that are required for universal coverage."[29]

For the past eight years, that commitment has been sorely lacking for New York's neglected Direct Pay market. "Mid-course corrections" to the CR/OE law — adopted with 1995's Point of Service Law and HCRA

23 Fuhrmans B. November 17, 2008. Small firms shiver as health premiums rise. *Wall Street Journal.*

24 Kofman M and K Pollitz. April 2006. *Health insurance regulation by states and the federal government: A review of current approaches and proposals for change.* Washington, DC: Georgetown University Health Policy Institute.

25 Holahan D, A Cook, and A. Williams. 2008. *Health insurance coverage in New York, 2005-2006, Figure 19.* New York: United Hospital Fund.

26 Holahan 2008. Figure 20.

27 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2008. *2008 Medical Expenditure Panel Survey—insurance component.* Table II.C1.

28 Hall 2000. [Note 21]

29 Nichols 2000. [Note 7]

2000, which provided a stop-loss subsidy for the Direct Pay market — are examples of the state acting to bolster its "we're all in this together" vision of insurance markets.

The Point of Service law was a bid to increase the size of the Direct Pay pool and limit adverse selection by product design, but subsequent decisions — such as the Healthy NY program for individuals, and increased access to association plans — have thinned the ranks of potential enrollees. While premium rates and adverse selection have increased, the stop-loss subsidy for the Direct Pay market has not been boosted since 2000, and has in fact been reduced in each of the past two years. State support for Healthy NY stop-loss funding has, in contrast, increased exponentially.

Last of the Pure States?

New York now stands alone among reform states in prohibiting age and sex rating in its individual and Small Group markets. Neighboring New Jersey finished the repeal of its pure community rating statute for individuals in 2008, and replaced it with age-based rating bands that allow a 350 percent spread in rates between the young and the old — although policymakers there did "flinch," capping rate increases for some older subscribers at 15 percent annually for four years. New York State also announced that it would study the impact of introducing limited age rating into the Small Group market as part of the Partnership for Coverage modeling project,[30] while also exploring an increase in the size of what constitutes a small group. Massachusetts solved the problem of isolated experience in Direct Pay pools by merging its Small Group and Direct Pay markets in 2007.

At the same time, Congressional health care reform proposals would sharply limit underwriting practices nationally, much as New York currently does, permitting only limited age rating.

Time will tell if New York is to be the last of the "pure" community rating states. But if, in fact, that's so, just how did New York end up with that distinction? According to interviews with former lobbyists and executive branch and legislative staffers, as the 1992 legislative session drew to a close and Senate majority members felt increasing pressure to act on the Cuomo Administration proposal, they sounded out the health insurance industry on a compromise that would substitute "adjusted community rating" with rate bands for demographic factors. At an emergency weekend conference call among Health Insurance Association of America board members, however, that compromise was rejected. Health plan executives, concerned with the precedent it would set in other states, ignored advice by professionals on the ground, and decided to roll the dice in an all-out bid to defeat the plan. The rest, as they say, is history.

30 New York Partnership for Coverage. June 30, 2008. Modeling of options for expansion of health insurance coverage for New Yorkers. http://www.partnership4coverage.ny.gov/reports/modeling_instructions_2008-06-30.htm.

Appendix F: Risk Adjustment

Risk Adjustment Mechanisms

Four distinct "risk adjustment mechanisms" raise and distribute over $300 million to offset claims costs and reduce premiums for individuals and workers enrolled in New York's individual, Small Group, and Healthy NY markets. Funding for the programs comes from a mix of sources, including the state's General Fund, the HCRA Tobacco Control and Insurance Initiatives Pool, and assessments on health plans in the individual and Small Group markets.

The Long and Tortured History of "Reg. 146"

During a tumultuous period characterized by landmark statutory and regulatory changes, health plan consolidations, conversions, and liquidations, the one constant over the last fifteen years may well be the *Sturm und Drang* surrounding "Reg. 146,"[1] the regulation adopted by the State Insurance Department (SID) to implement the risk mitigation measure adopted as part of the 1992 CR/OE law.

A late starter in marathon negotiations on the CR/OE law, the need for a risk adjustment factor was advanced in the final weeks by the Cuomo Administration, and pitched in a way that had appeal to all sides on the issue. Commercial insurers like MetLife and Prudential, which predicted a "rush to quality" when market reforms freed subscribers trapped at Empire, liked the idea of a protection against an influx of high-risk enrollees. Empire officials, worried that their coterie of higher-risk customers would simply stay put, saw an opportunity for all health plans to help shoulder the burden of their high-cost customers. SID officials saw the need for an enforcement mechanism that would deter insurers from "gaming the system" and avoiding high-cost customers by removing the financial incentive to do so, and providing stability during an ambitious and somewhat unpredictable market reorganization.

The final legislation included three brief paragraphs — "Stabilization of Health Insurance Markets and Premium Rates" — that gave the Insurance Department broad authority to promulgate regulations to "assure an orderly implementation and ongoing operation of the open enrollment and community rating law… including provisions designed to encourage insurers to remain in or enter the small group or individual health insurance market." The regulations were intended to "promote an insurance marketplace where premiums do not unduly fluctuate, [and] insurers and HMOs are reasonably protected against unexpected significant shifts in the number of persons insured," and to "share the risk of or equalize high claims and claims of high-cost persons."[2]

At the time, no state had attempted to develop such a mechanism. Working without a roadmap but in consultation with a statutorily mandated "technical advisory committee" made up of health plan representatives and consumer groups, the SID worked feverishly to put the plan in place. In December of 1992, the SID promulgated Regulation 146, which called for the creation of two risk adjustment pools in seven regions in the state for individual and small group

1 11NYCRR 361.

2 NYIL Section 3233(a).

health insurance, one based on demographic factors and a second on "specified medical conditions" (SMC).

A third pool, also based on demographic factors, was established in the same seven regions for Medicare Supplement subscribers. In each case, the regional pools would operate independently.

For the demographic pools, health plans reported detailed information on the age and sex of their enrollees and the SID developed regional averages based on the data. Plans with "demographic factors" higher than the average would receive payments from the pool; health plans with below-average demographic factors would pay into the pools, based on their annual premiums and the extent of the difference between their demographic factor and the regional average.

Contributions to the SMC pools were set at a $5 per contract fee (a forerunner of the HCRA covered lives assessments), and adjusted to reflect the family size and the relative comprehensiveness of the benefits provided. Alicare, a TPA subsidiary of Amalgamated Life, was chosen to administer the complex system. The regulation called for flat dollar amount payments to health plans to offset claims expenses for a limited number of medical conditions.

With the regulation set to take effect on April 1, health plan trade groups sued in March of 1993 to block the regulation in federal district court, arguing that it was preempted by ERISA. With feelings still running high from the bruising battle on the CR/OE law, health plans argued that the SID's implementation of the statutory language was designed to wholly benefit Blue Cross plans at their expense. HMOs in particular disliked the demographic design, maintaining that they were unfairly penalized because their demographics reflected the younger population they attracted due to their openness to managed care, rather than any sinister intent to risk select.

In February 1994, the district court granted a preliminary injunction against the regulation, but required health plans filing the lawsuit to deposit funds into escrow.

With the case on appeal, the SID continued implementing the collection side of the regulation, but the intent of the regulation was effectively blunted. A 1995 report by the administrator notes that "a consequence of these lawsuits is that most contributions are being made to escrow accounts and, therefore, limited funds are available for distribution." Over $54 million had been collected from carriers, but just $5.4 million had been distributed.[3] In addition to hamstringing the operation of the mechanism, the delays ushered in an era of nightmarish accounting problems for health plans, as they began carrying increasingly complex liabilities and credits on their books that extended back several years.

August 1995 saw the resolution of the Regulation 146 litigation, as the U.S. 2nd Circuit Court of Appeals reversed the decision of the lower court in the now consolidated lawsuits and allowed the SID to go forward.[4] But a new administration had taken over in Albany, with a strong interest in deregulation, and a new commissioner, Edward J. Muhl, was happy to carry it out.[5] Legislation adopted in 1995[6] directed the Insurance Department to reshape the risk adjustment mechanism, phasing out the demographic pool and replacing it with a beefed-up specified medical condition pool.

Although the statute required the

3 New York market stabilization pools. Report and financial statements for the fourth quarter of 1994. August 16, 1995. Prepared by Alicare, Inc.

4 New York State HMO Conference v. Curiale, 64 F.3d 794 (2nd Cir. 1995).

5 Pataki's chief for insurance takes new job. December 12, 1996. *New York Times*.

6 Chapter 504 of the Laws of 1995; NYIL Section 3233(c)(2).

elimination of demographic pool contributions from health plans by 2000, it did not set a hard deadline for the creation of the new specified medical conditions formulas. Under pressure from Assembly lawmakers and consumer groups in April 1998, the Pataki Administration released $110 million in funds that had built up in the pools to avert rate increases as high as 70 percent for individual subscribers at Empire and Oxford in what some viewed as an election year gambit,[7] but no overhaul of Reg. 146 was forthcoming. A new regulation was finally promulgated in February 2000[8] but was never implemented. Another version that called for the creation of regional "relative cost factors" based on medical diagnosis codes was promulgated in May of 2002,[9] but also bogged down. In February 2004, the SID issued a stern letter to health plans, chiding them for missing deadlines and submitting inaccurate or incomplete applications.[10]

In 2005, the Pataki Administration, although no litigation was pending, brought about an end to the sorry chapter by entering into a settlement agreement with health plans regarding past and future liabilities under Regulation 146.[11] Under the agreement, the Insurance Department repaid health plans funds remaining in the demographic pool payments in 1999 and 2000, and reduced plan payments by 12.5 percent for payments owed from 1999 to 2003, and by 50 percent for obligations in 2004. Also as part of the agreement, Reg. 146 pool payments for 2005 were suspended, in exchange for a one-time contribution by health plans to the Direct Pay stop-loss funds. Total figures on the stop-loss payments were not available, but the Insurance Department announced $71 million in refunds and credits for Direct Pay subscribers in August of 2006, effectively closing out the Reg. 146 checking account.[12]

Under a new administration, and with most health plans clamoring for the elimination of Regulation 146, the Insurance Department tried a new tack, preserving the risk adjustment mechanism but using a formula that resembles the stop-loss programs for Direct Pay and Healthy NY subscribers.[13] Under the system, health plans report claims in excess of $20,000 within a region, and pay or receive disbursement based on whether their frequency of high-cost claims is higher or lower than the regional average. The regulation caps health plan pool contributions at $80 million for the 2007 calendar year, $120 million for 2008, and $160 million for 2009.

The new regulation addresses some but not all of the health plans' concerns. It is considerably less complex, although health plans still have a number of objections. Each plan's high-cost claims are fairly predictable, although estimating the regional average on which payouts or collections are based involves some guesswork. Under the structure of the mechanism, health plans still file individual and Small Group rates in the fall without knowing the exact amounts they will pay or receive from the pools for several months.

Some health plans question whether the current formula, with a $20,000 threshold and no upper limit, rewards health plans that don't actively manage care and costs, at the

7 Albany to pay to stabilize health premiums. April 22, 1998. *New York Times*.

8 3rd Amendment to Regulation 146, New York State Insurance Department.

9 4th Amendment to Regulation 146, New York State Insurance Department.

10 Circular Letter No. 1 of 2004. New York State Insurance Department.

11 Master Settlement Agreement. June 29, 2005. Obtained through FOIL request.

12 New York State Insurance Department. August 17, 2006. New York secures $71 million for health plan policyholders. [Press release]

13 5th Amendment to Regulation 146. Finalized June 5, 2008. New York State Insurance Department.

expense of those that do, and fails to take into account amounts plans receive under the direct pay stop-loss pool (see below). By far, the larger issues, however, are whether the Small Group market should subsidize the Direct Pay market through this mechanism, and what additional role the mechanism should play — if any — going forward.

A recent Fund report estimates that under a "trial run" of the new rules conducted by the Insurance Department, Regulation 146 payments resulted in an 8.5 percent decrease in Direct Pay rates, and a 1 percent increase in Small Group rates. Simply eliminating the Reg. 146 subsidy would result in a proportionate increase in Direct Pay premiums, pushing annual increases higher for families already paying thousands of dollars a month for coverage. Boosting the funding available through the stop-loss program, an iffy proposition given the pressures on the state budget, could replace Reg. 146 subsidies. And the two separate but nearly equal subsidy mechanisms, Regulation 146 and the Direct Pay stop-loss program, are not coordinated.

Assessing large employer groups for this purpose would ease the impact on Small Group premiums. But replacing a risk adjustment mechanism funded from within the market with outside subsidy funds to some degree undercuts its utility as a mechanism to enforce the terms of the CR/OE law, by removing a market advantage for plans able to attract lower-risk customers. The market-based contribution funnels any gains for plans with lower-cost customers to plans with higher-cost customers, so the claims experience in the market is reflected in the premiums all health plans charge.

Today, Reg. 146 is tangled in the multiple roles it has played since its inception — post-CR/OE law market stabilizer, Direct Pay subsidizer, and risk-avoidance market cop — and the different expectations people have had since the beginning. Though something of a "blunt instrument," Reg. 146 has restricted health plans' ability to avoid risks. While any turmoil and dislocation that resulted from the CR/OE law fifteen years ago has long made its way through the system, the value of a mechanism to distribute risks seems reasonable. And should state policy-makers decide to merge the Direct Pay and Small Group markets, a properly constituted Regulation 146 could protect health plans that attract a disproportionate share of higher-risk customers. Evolving product designs are gradually creating another role for a similar mechanism. With the health insurance market moving toward high-cost share designs, Regulation 146 could protect those plans offering comprehensive benefits — like HMOs — from adverse selection. And many commentators on federal health care reform have opined that risk adjustment is a critical component in the design of a health insurance exchange.

Oddly, the debate on Reg. 146 has occurred outside the context of similarly designed risk adjustment mechanisms for New York State public managed care programs and the federal Medicare Advantage program. Risk adjustment mechanisms used for both of these programs adjust health plan premiums to reflect enrollees' medical conditions. Many of the health plans active in the commercial market are active in these two public markets as well. Risk adjustment for the public programs is made infinitely easier because government entities pay the entire premium to health plans directly, while Reg. 146 layers payments on top of premiums that individuals and employer groups pay. But the path to a better Reg. 146 may lie in careful analysis of what works in the public program mechanisms, and is transferrable to the commercial market.

Direct Payment and Healthy NY Stop-Loss Funds

The direct payment and Healthy NY stop-loss funds, created under the HCRA 2000

legislation, provide premium subsidies to enrollees in the Direct Pay market and the Healthy NY program through reinsurance payments to HMOs. In their design, the funds function in a similar fashion to the stop-loss coverage most health plans purchase themselves — insurance policies that cover high-cost claims. Although adopted in tandem, the market impact of the two funds is dramatically different, shaped by robust funding of the Healthy NY fund and regulatory changes providing a more generous subsidy, and chronic underfunding of the Direct Pay fund.

Both of the funds create separate pools for categories of enrollees, but the funds are interchangeable within each program. The Direct Pay program includes separate stop-loss pools for enrollees in the standardized HMO product and the standardized POS product. Under the statute creating the program, the Direct Pay stop-loss program reimburses health plans for 90 percent of an individual's health care claims that fall into a "corridor" of $20,000 to $100,000 annually. Claims incurred below $20,000 and above $100,000 for an individual in a year are not eligible for reimbursement. Claims data collection and payments are supervised by a vendor hired by the SID.

Although more members are enrolled in the HMO product (44,000 versus 13,000 for the POS product), the POS product generates more and higher-cost claims, and thus receives a higher proportion of stop-loss payments when measured on a per-member basis.

In 2006, health plans filed nearly $62 million in eligible claims based on the experience of 2,900 members enrolled in the HMO product, and received $20 million in stop-loss reimbursement, or 32 percent of eligible claims. HMOs filed claims of almost $40 million for 1,756 enrollees in the individual POS product, and received $20 million, which represents 51 percent of the cost of eligible claims.

The subsidy now represents less than 10 percent of the total premium for the Direct Pay standardized products. Overall, the stop-loss payments provide a subsidy of 7.3 percent for Direct Pay subscribers.[14] Full funding of eligible claims would have required an additional $55 million annually in 2006, which would represent over 20 percent of the market premium. The state budget adopted in FY 2008-09 included a 2 percent cut to HCRA appropriations, reducing funding for the Direct Pay stop-loss program from the original $40 million by $800,000, and the percentage of eligible claims reimbursed in both markets.

Viewing the historic claims experience and enrollment in the Direct Pay market and in the context of the stop-loss program provides another verification of the adverse selection that has gripped the market. With enrollment estimated at over 100,000, nearly twice as high as today,[15] health plans filed eligible HMO claims of $34.5 million and POS claims of $35.9 million, and were reimbursed for 57 percent and 54 percent of the claims, respectively.[16] That compares to over $102 million total eligible claims filed in 2006, and reimbursed at 32 percent and 51 percent, respectively.

Intended to "ensure that individual consumers have continued access to comprehensive health insurance,"[17] the Direct Pay stop-loss program spares current enrollees the full brunt of annual double-digit rate increases, but has become increasingly irrelevant in terms of preserving market

14 Gorman Actuarial LLC. 2008. *Merging the markets: Combining New York's individual and small group markets into common risk pools.* New York: United Hospital Fund.

15 New York State Insurance Department. 2007.

16 New York State Insurance Department. 2003. Annual report of the superintendent.

17 Ibid.

access. In recreating a viable individual market, state policymakers will have to confront the question of whether a full financial commitment is the answer, or if a different mechanism should be considered.

The Healthy NY stop-loss program mirrors the Direct Pay program, with two important differences: eligible claims include those within a much more generous stop-loss corridor of $5,000 to $75,000 annually, and steady increases in funding have kept pace with growing enrollment and claims volume so that the health plans have received 100 percent reimbursement of eligible Healthy NY claims since the program's inception.

Three populations are subsidized through claims reimbursement from two funds within the Healthy NY stop-loss program — individuals, sole proprietors, and small group members. The qualifying individual fund made payments of $58.6 million on behalf of the 7,400 individuals (out of 103,000 enrolled at some point during the year) who incurred claims in excess of $5,000. The qualifying small employer fund made payments to health plans of $16.1 million for eligible claims incurred by 2,100 sole proprietors (out of 27,700 enrollees) and $17.6 million related to claims by 2,500 small employer group members (out of 45,000 enrolled).[18] SID officials estimate that the cumulative $92 million in stop-loss payments provides a roughly $63 monthly subsidy for enrollees, a roughly 30 percent subsidy.[19] Overall, sole proprietor Healthy NY members receive the highest level of subsidy, followed by individuals and then small group members.[20]

SID officials overseeing the stop-loss programs point with pride to the national attention they have received from state and federal policymakers and academics, and praise the elegance and simplicity of the program design. Health plans appreciate the administrative ease and certainty of the programs, which are much less cumbersome than those that direct subsidies to individuals to pay a portion of the premium. But Healthy NY demonstration programs like Brooklyn Healthworks and the UnitedHealthcare/Syracuse Chamber of Commerce "HealthCore" program provide individual subsidies to health plans in addition to the stop-loss subsidies.

Timothy's Law

After ten years of emotional debate and candlelight vigils outside the State Capitol, New York adopted legislation in 2006 to require more extensive mental health benefits for Small and Large Group policies.[21] Known as "Timothy's Law," after Timothy O'Clair, an emotionally troubled young boy whose suicide galvanized support for the effort, the law fell short of the true "mental health parity" supporters sought, but mandated that each Small Group policyholder receive a guaranteed twenty outpatient visits and thirty days of inpatient treatment each year for mental and emotional disorders.

The guarantee replaced a provision that required health plans to offer the benefit through a rider at the option of the employer group, known as a "make available." In order to resolve an impasse over the premium impact of the new benefit on small business health insurance rates, state lawmakers — desperate to resolve the issue — settled on a novel approach: state taxpayers would foot the bill for the new Small Group benefit. The legislation included language requiring the superintendent to "develop and implement a methodology to fully cover the cost to any such group purchaser for providing the

18 New York State Insurance Department. Healthy NY cumulative quarterly loss ratios reports for individual, sole proprietor, small group and all lines, January 1-December 31, 2006.

19 New York State Insurance Department, United Hospital Fund policy roundtable. May 11, 2007.

20 Gorman Actuarial 2008. [Note 14]

21 Chapter 748 of the Laws of 2006.

coverage… Such methodology shall be financed from funds from the General Fund that shall be made available to the superintendent for such purpose."[22] State General Fund appropriations of $100 million were approved in the two succeeding state budgets.[23]

With barely two weeks to implement both the new mandate (which included a handful of technical flaws) and the new risk mitigation program, SID officials instructed health plans to provide the benefit immediately and resubmit rate filings that calculated the cost of the benefit on a per member per month basis, and provide refunds or credits to Small Group policyholders based on the new state subsidy.

In May 2009, state officials released a report on the impact of Timothy's Law on coverage and premium costs,[24] and the legislature acted favorably on Governor Paterson's recommendation that the law be made permanent.[25] While noting the improvement of mental health benefits in both the Small and Large Group markets, the study shows that 42 percent of Small Group market insureds were already receiving mental health benefits equal to or exceeding the new mandate, and another 57 percent were receiving some mental health coverage, but less than the law required. The lion's share of the subsidy, then, helped offset current costs of providing mental health benefits, rather than subsidizing new coverage. The analysis shows the shortcomings of "actuarial value" assessments of mandated benefits discussed earlier.

22 NYIL Sections 3221(1)(5)(D)(ii) and 4303(g)(4) and (h)(4).

23 See S.6805-D/A.9805-D, Transportation, Economic Development and Environmental Conservation Budget Bill, 2008-2009, Insurance Department, Regulation Program.

24 Report by the Superintendent of Insurance on the cost and effectiveness of New York's 2006 Mental Health Parity Legislation ("Timothy's Law"). May 2009.

25 Governor Paterson announces legislation to make Timothy's Law permanent; Accepts study from Insurance Department on effectiveness of mental health parity. [Press release] May 5, 2005.

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