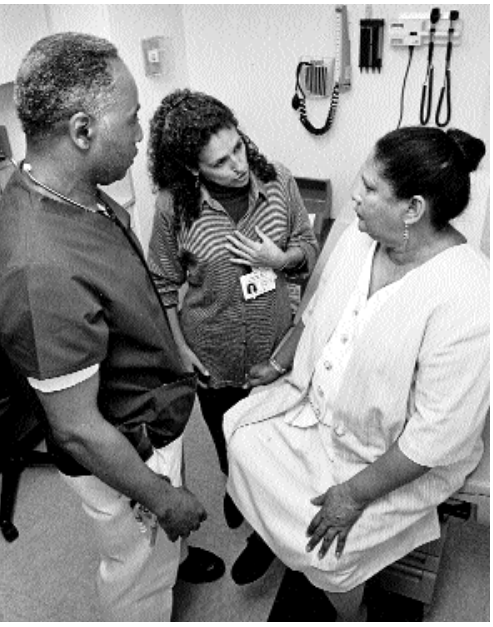
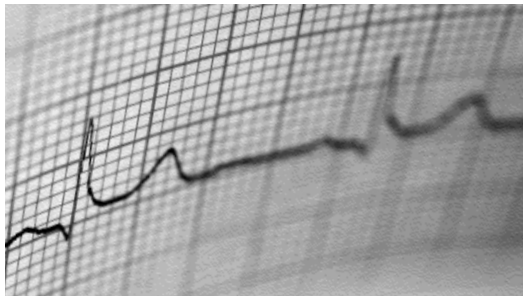
United Hospital Fund

Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools





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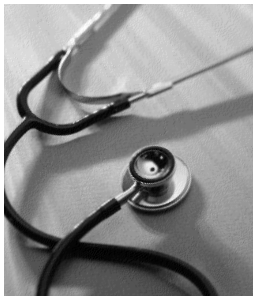

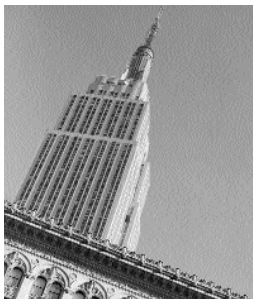

United Hospital Fund

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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Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools

Prepared for the United Hospital Fund by
Gorman Actuarial, LLC

UNITED HOSPITAL FUND

ISBN 1-88127-7895

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Foreword

Recreating a viable market in which individuals can purchase affordable, comprehensive health insurance policies has become a focal point of universal coverage discussions in New York State. New York's Direct Pay market, in which individuals and families buy health coverage without contributions from employers, is in critical condition.

Enrollment in the two major HMO products authorized in 1995 has plummeted from about 111,000 members in 2000 to an estimated 45,600 enrollees at the end of 2007. The exodus was no doubt triggered by explosive premium growth in the market, as rates have now reached as high as $4,300 a month for family coverage in Manhattan, $3,600 in Albany, $2,600 in Rochester, and $2,900 in Buffalo. Funding for a reinsurance program intended to offset concentrations of sicker individuals in the market hasn't been increased since its inception in 2000. And as enrollment drops, premiums are based on the medical claims of increasingly smaller groups of persons who have managed to hang on, particularly in upstate markets.

One of the options being considered by policymakers to shore up the Direct Pay market is the idea of "merging" that market with two other distinct market segments: the Healthy New York market, with an enrollment of 147,000 individuals, sole proprietors, and small-business employees, and the Small Group market, about 1.7 million sole proprietors and workers in small businesses. While all three of these segments are community-rated, rates are developed separately for each group.

The option of stabilizing the Direct Pay market through a merger is certainly entwined in New York's health insurance "DNA." Well into the mid-1990s, Blue Cross/Blue Shield plans in regions such as Rochester offered coverage under which premiums for individuals, small groups, *and* large groups were based on the experience of one community pool. But this "back to the future" option drew renewed attention in 2006 when Massachusetts approved a merger of its Direct Pay and Small Group markets as part of its sweeping health care reform plan. Two New York Blue Cross insurers, Excellus and Empire, have since proposed a variation on the plan as part of a broader reform agenda, highlighted at a United Hospital Fund roundtable in May 2007.

While a merger of market segments would likely stabilize the Direct Pay market — providing rate relief and more product choices for individual purchasers — the risk of such a reform is that it might increase rates for small-business and Healthy New York customers. In order to better understand this approach, the United Hospital Fund commissioned Gorman Actuarial, LLC, to perform a study that would model the impact on premiums for enrollees if the three market segments were merged.

While this study focused on the impact on premiums of a merger, it also provides illuminating profiles of these market segments. Direct Pay market enrollees, for example, incur twice as many medical claims a month on average as Small Group members; Healthy New York enrollees, in turn, are 10 percent "healthier" than Small Group members. And while many have cited the quality of Direct Pay standardized benefits

as a significant factor in the market's decline, the study estimates that the benefit package for individuals is only about 5 percent more comprehensive than Small Group health benefits.

A successful universal coverage effort will require simultaneous thought and attention to both public and commercial markets. This study provides some insights into the profile of New York's commercial market for individuals and small businesses, and a clear-eyed look at one approach to shoring up New York's neglected Direct Pay market.

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Acknowledgments

This report was funded by grants from the New York State Health Foundation (NYSHealth) and the New York Community Trust. The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The New York Community Trust makes grants for a universe of charitable activity important to the well-being and vitality of the city. The views presented here are those of the authors and not necessarily those of either foundation or their directors, officers, or staff.

Executive Summary

As of December 2007, some 1.932 million individuals, small-business owners, and workers were covered through three distinct segments of New York's commercial health insurance market: Direct Pay, Healthy New York, and Small Group.

Market Rules

The Direct Pay market is made up of individuals who purchase coverage directly for themselves and their families, without involvement by employers. The Healthy New York sector consists of enrollees in a state-subsidized program for individuals and sole proprietors earning less than 250 percent of the Federal Poverty Level, and for small-employer groups in which at least one-third of employees earn less than $36,500 annually. The Small Group market is New York's major, unsubsidized market for sole proprietors and employer groups of between two and fifty employees.

All three of these market segments are governed by rules established in New York's Community Rating and Open Enrollment law.[1] Health plans must accept all applicants for enrollment at any time during the year regardless of their health status, cannot terminate enrollees due to their claims experience, and cannot vary rates for individuals or employer groups based on age, sex, medical status, or occupation. Instead, premiums must be based on the average costs of insuring enrollees who have purchased a similar product in a given region of the state, and can otherwise reflect only family size.

Rules for the Direct Pay market were also shaped by another major reform, New York's 1995 Point of Service Law.[2] Under its provisions, the state's health maintenance organizations (HMOs) were required to offer two standardized, comprehensive health benefit packages to all individuals. One of these is the standard HMO mode of service, while the other — known as a Point of Service (POS) option — permits enrollees to seek care from out-of-network providers. The Small Group market is characterized by HMO/POS coverage as well as product choices unavailable in the Direct Pay market, such as Preferred Provider Organizations (PPOs) or Exclusive Provider Organizations (EPOs) — in which services are provided through network providers, often without prior authorization requirements, and sometimes with an out-of-network benefit — as well as indemnity coverage.

The Healthy New York program was launched in 2000 as part of the Health Care Reform Act legislation (HCRA 2000).[3] HMOs were required to offer individuals, sole proprietors, and small groups a streamlined benefit package, lacking certain benefits required in the Direct Pay and Small Group markets. Premiums are uniform, based on the combined costs of all three eligible groups, rather than on each group's claims experience. Rates are also subsidized, through state reinsurance payments directly to health plans. These "stop-loss" payments offset a portion of health plans' claims costs in order to reduce the overall premium costs to participating

1 Chapter 501 of the Laws of New York, 1992
2 Chapter 504 of the Laws of New York, 1995
3 For further information on HCRA 2000, see www.health.state.ny.us/nysdoh/hcra/hcrahome.htm.

Healthy New York enrollees. HCRA 2000 also created a separate but more limited stop-loss program for the Direct Pay market.

Since 1994, the Direct Pay and Small Group markets have been subject to a separate risk adjustment mechanism, designed to protect individual health plans from the premium impact of insuring a disproportionate share of older or sicker individuals compared to their competitors.[4] Under the program, which has operated in fits and starts since its inception, health plans pay an assessment into a regional pool, based on their enrollment in the markets, and those health plans with higher numbers of older or sicker individuals than the average for a region receive funds from the pools. Collectively, these types of risk-adjustment and reinsurance mechanisms are known as "risk mitigation" programs.

Market Profiles

Enrollment has grown slowly but steadily in the Healthy New York program, reaching 148,000 as of December 2007. Small Group market enrollment experienced a modest decline to 1.7 million in 2007. Enrollment in Direct Pay HMO/POS products has plummeted, however, declining from over 100,000 in 2000 to just 57,000 enrollees as of December 2006. Membership continued to decline in 2007, with an estimated 45,600 enrollees at year end. Also as of December 2007, there were an estimated 38,500 Direct Pay members enrolled in non-HMO/POS products.

Prompted by the sense that universal coverage efforts require a viable Direct Pay market, policymakers have begun to consider a number of options to address the problem. One of these involves "merging" the three distinct markets into a single risk pool, in which premiums would be developed based on the medical claims experience of the markets as a whole. The United Hospital Fund commissioned Gorman Actuarial, LLC, to perform a study of the impact on enrollee premiums in the three market segments if such a merger were undertaken.

In a sense, merging the Small Group and Direct Pay market segments would mirror the current rating scheme of the Healthy New York program, under which individuals, sole proprietors, and small-business owners and employees pay premiums based on their aggregate claims experience.

Determining the premium impact on the market segments required a number of calculations before the modeling could take place. First, each market segment's share of total enrollment was identified. Next, the benefit packages covering enrollees in each market segment were valued and compared. Then, the frequency with which enrollees in each market segment used medical care was determined, along with the relative cost of those health care claims, to determine what is known as "intensity." We use the term "morbidity" to describe the relative frequency and severity of claims for an insured population. Finally, the impact of risk mitigation mechanisms on rates was evaluated.

This portion of the study found that:

- The Direct Pay market represents

[4] 11 New York Codes, Rules and Regulations (NYCRR) Part 361

approximately 4.4 percent of the total of the Small Group, Healthy New York, and Direct Pay markets;

- Benefits provided to individuals through the standardized HMO/POS products in the Direct Pay market are, on average, 5 percent richer than those of the Small Group market and 15 percent richer than those of Healthy New York;
- Direct Pay market enrollees typically incur twice as many medical claims each month as Small Group market members;
- The Direct Pay market's morbidity is estimated to be 200 percent higher than the Small Group market's, while Healthy New York's is estimated to be 10 percent lower than that of the Small Group market;
- Over 75 percent of Direct Pay market enrollment, versus 58 percent of Small Group enrollment, is located in the New York City region — the costliest in the state; and,
- Surprisingly, the Direct Pay HMO/POS market was the most profitable for health plans in 2006, with a 5.4 percent profit margin, compared with the Small Group market's 4.6 percent. These reported results reflect subsidies and payments, however, stemming from the state's Regulation 146 market stabilization program, and from premium deficiencies, which are special reserve funds that health plans sometimes establish to safeguard against costs exceeding premiums for a particular product.

Merger Scenarios

Since the three market segments are subject to varying risk mitigation programs, we modeled three different merged market scenarios. Overall, we determined that premiums for the Small Group and Healthy New York markets would increase as a result of a merger, and premiums for the Direct Pay market would decrease. This means that some small-business employers would receive higher-than-average rate increases, some premiums would stay the same, and some would decrease, with similar results for individuals. Levels of premium increase or decrease might also vary based on an individual health plan's mix of business. For the purposes of this analysis, we assumed that individuals and employers would remain in their current plan designs.

Under Scenario 1, we modeled the premium impact of merging just the Direct Pay and Small Group markets, with the following result:

Scenario 1

Direct Pay	Small Group
-37.2%	3.1%

Under Scenario 2, we modeled the premium impact of merging the Direct Pay, Healthy New York, and Small Group markets, transferring the full value of the current Healthy New York stop-loss subsidy to the new merged market, with the following result:

Scenario 2

Direct Pay	Healthy New York	Small Group
-38.4%	43.7%	0.6%

Under Scenario 3, we modeled the premium impact of merging the Direct Pay, Healthy New York, and Small Group markets, with Healthy New York enrollees retaining the full value of the stop-loss subsidy, with the following result:

Scenario 3

Direct Pay	Healthy New York	Small Group
-37.6%	16.1%	2.2%

We also explored ways to mitigate premium increases for the Small Group market in the event of a merger. One policy that would temper the Small Group market rate increase is to introduce a group size adjustment for "groups of one," similar to the surcharge that sole proprietors currently are assessed when they purchase Small Group coverage through associations. Modeling the impact of a range of group size adjustments — 10 percent, 15 percent, and 20 percent — we found that the premium impact of the merger on Small Group members under Scenario 1 could be reduced to 2.6, 2.4, and 2.2 percent, respectively, while at the same time preserving an approximate 29 percent rate decrease for individuals.

Additionally, we investigated the possibility of mitigating the impact of a merger on the Small Group market through a reinsurance mechanism. We estimate that in Year 1, about $128 million in new funding would be required to eliminate the 2.4 percent premium increase for the Small Group market under Scenario 1, when coupled with a group size adjustment of 15 percent. We also provide a range of reinsurance funding requirements, and possibilities for structuring the program.

This modeling project rests on a series of assumptions. We believe the one most likely to alter the results of our modeling is the respective market share of each market segment. In order to test the impact of larger-than-expected declines in Direct Pay market enrollment, we conducted various sensitivity analyses and found, as expected, that Small Group market premium impact decreases as Direct Pay enrollment drops.

Finally, we examined the impact of a merger in terms of new membership and the uninsured. We estimate, based on elasticity surveys, that with decreased premium rates in the Direct Pay market under Scenario 1, 11,700 new members would join the market. We also found that these newly insured members would have a negligible impact on the overall pool of the merged market.

The large state subsidy and more favorable morbidity in the Healthy New York market, compared to other segments, would require special attention to avert an adverse impact on the Healthy New York population in a market merger. Merging the Small Group and Direct Pay markets would provide significant rate relief for individuals, stabilize the downward spiral in this market, and increase product options for individuals. Absent an individual mandate to purchase coverage, however, merging the Direct Pay and Small Group markets would result in only modest growth in the insured pool.

Introduction

New York State's Partnership for Coverage initiative has spurred renewed interest in bringing about universal health insurance coverage for all New Yorkers. State policymakers recently moved to boost enrollment in New York's two key public programs — Child Health Plus and Family Health Plus — by removing barriers to enrollment and recertification and, for the children's health program, increasing income eligibility levels to 400 percent of the Federal Poverty Level. While these public programs have flourished, enrollment in the commercial market has been declining.

This is particularly evident in the Direct Pay market for individual, non-employer-based insurance. There, enrollment in HMO/POS products[5] has dramatically declined, at the same time that monthly premiums for family policies have reached as high as $4,300, with rates based on the claims experience of increasingly smaller pools of the insured, particularly upstate.

Prompted by the sense that universal coverage efforts require a viable Direct Pay market, policymakers have begun to consider a number of options to address the problem. One of these involves "merging" the three distinct markets — Direct Pay, Healthy New York, and Small Group — into common risk pools, in which premiums would be developed based on the medical claims experience of the markets as a whole.

To fully understand the effects of such a merger, the United Hospital Fund commissioned Gorman Actuarial, LLC, to conduct a study of the impact on premiums and enrollment. The findings, reported here, are based on data provided by the New York State Insurance Department and the United Hospital Fund, as well as data analyses and modeling.

A number of key assumptions also underlie this report:

- On average, a market merger will increase rates for small-employer groups. Some of these groups will receive increases higher than the average, some will receive increases lower than the average, and some will not experience any rate change.
- All models assume that small-group employers and individuals would remain in their current plan designs — although individuals would have the ability to purchase products that are currently offered only to the small-employer market.
- The Direct Pay market includes members insured under non-HMO/POS products, which were grandfathered in under the 1992 Community Rating/Open Enrollment law, and members who purchased HMO/POS products both before and after the enactment of the 1995 Point-of-Service Law. It is possible that some members with non-HMO/POS coverage will not be merged with the Small Group market because comparable products are not available. This modeling, however, assumes that all Direct Pay members enrolled in non-HMO/POS coverage would be merged with the Small Group non-HMO/POS market. This is a conservative assumption in terms of the premium impact of a merger on the Small Group market, since a smaller Direct Pay population would produce less of a premium impact.
- Any analyses that show regional cost differences assume that utilization patterns, plan designs, and age demographics are similar across regions.
- Due to data restrictions, these analyses do not take into account the proportion of individual versus family contracts, or average family size. In general, based on

[5] The term "HMO/POS products" refers to health coverage offered by HMOs in the traditional manner, through a network of participating providers by referral from a primary care physician, or with the added option of a "point-of-service" (POS) benefit, which allows members to see out-of-network providers.

our work in other states, the Small Group market has higher average family sizes and a greater proportion of family policies than the Direct Pay market. If this is also true for New York, then increases for the Small Group sector under a merged market may actually be lower than projected.
- Estimated premium impacts related to risk mitigation programs (discussed below) were based on 2006 funding and claims information for the various market segments. If funding amounts increase with claims trends, results of these analyses may be used in future years.

Since data limitations did exist, some of our assumptions were based on other states' experience and may not specifically reflect New York's. Where that is the case we have noted it. Finally, this report does not make any specific recommendations regarding a preferred policy, but rather states the results of our analyses.

We would like to thank the New York State Insurance Department for its assistance in obtaining and interpreting information for this study. The United Hospital Fund's Health Insurance Project Co-Director Peter Newell also made significant contributions to this report.

Data Sources

Because there is no single source of data for the Small Group and Direct Pay markets, this study relied on a variety of data sources to determine the landscape of New York's insurance market. Through the New York Freedom of Information Law, we were able to obtain public documents — filings required by law and regulations — from the New York State Insurance Department, including:

- Annual Statements from all of the different types of health plans offering coverage in these markets, which are filed with the National Association of Insurance Commissioners (NAIC) and the state Insurance Department;
- Supplements to the NAIC annual statements that are filed with the state Insurance Department; and
- A sampling of Insurance Law Section 4308(h) Loss-Ratio Filings, which health plans must file in conjunction with requests for premium increases.

Along with the above statements, the Insurance Department provided a database that included a subset of the required data for the Regulation 146 market stabilization program (discussed below), edited to prevent the identification of specific carriers.

Plan design information for the Small Group market was obtained through high-level surveys submitted to the Insurance Department by a sampling of insurance carriers. The surveys were summarized, and specific carrier identification removed, by the Department. We also referenced the 2007 Healthy New York Annual Report.

Some of the data used in this report were collected on a regional basis. Table 1 shows the counties making up each region.

Upon review of all the data sources, numerous issues were discovered, including missing, conflicting, and unavailable data. In these cases, we relied on our experience with other states, as well as guidance from the New York State Insurance Department and the United Hospital Fund, to adjust the information. Due to these data issues, many of the results shown are estimates.

Background

Markets

The Direct Pay market is made up of individuals who purchase coverage directly, for themselves and their families, without involvement by employers. The Healthy

Table 1: **New York's Regions Defined**

	Region						
	Albany	**Buffalo**	**Mid-Hudson**	**New York City**	**Rochester**	**Syracuse**	**Utica/Watertown**
COUNTY	Albany	Allegany	Columbia	Bronx	Livingston	Broome	Chenango
	Clinton	Cattaraugus	Delaware	Kings	Monroe	Cayuga	Franklin
	Essex	Chautauqua	Dutchess	Nassau	Ontario	Chemung	Hamilton
	Fulton	Erie	Greene	New York	Seneca	Cortland	Herkimer
	Montgomery	Genesee	Orange	Queens	Wayne	Onondaga	Jefferson
	Rensselaer	Niagara	Putnam	Richmond	Yates	Schuyler	Lewis
	Saratoga	Orleans	Sullivan	Rockland		Steuben	Madison
	Schenectady	Wyoming	Ulster	Suffolk		Tioga	Oneida
	Schoharie			Westchester		Tompkins	Oswego
	Warren						Otsego
	Washington						St. Lawrence

New York sector consists of enrollees in a state-subsidized program for individuals and sole proprietors earning less than 250 percent of the Federal Poverty Level, and for small-employer groups in which at least one-third of employees earn less than $36,500 annually. The Small Group market is New York's major, unsubsidized market for sole proprietors and employer groups of between two and fifty employees. Sole proprietors can access this market through membership in an association, but can be charged a 15 percent surcharge above the Small Group rate.

All three of these market segments are governed by rules established in New York's Community Rating and Open Enrollment law. Health plans must accept all applicants for enrollment at any time during the year regardless of their health status (subject to pre-existing condition waiting periods), cannot terminate enrollees due to their claims experience, and cannot vary rates for individuals or employer groups based on age, sex, medical status, or occupation. Instead, premiums must be based on the average costs of insuring enrollees who have purchased a similar product in a given region of the state, and can otherwise reflect only family size. Health plans are permitted, however, to maintain separate community rates for Direct Pay subscribers and Small Group members.

Within the Small Group and Direct Pay markets, there are several community rating pools. Although state Insurance Department regulations require health plans to base rates for "substantially similar" products on the experience of one pool, health insurers can create several rating pools within each market by selling policies with different structures or benefits. For example, if a health insurer markets a PPO product and an HMO product to the Small Group market, each product may be sold under a different contract form. This allows the health insurance carrier to set two separate community rates, one for the HMO product and one for the PPO product. It is unknown how many rating pools there are within each market.

Rules for the Direct Pay market were also shaped by another major reform, New York's Point of Service Law. Under its provisions, the state's HMOs are required to offer two standardized, comprehensive health benefit packages to all individuals. As noted earlier, one of these is the standard HMO mode of

service, while the other — the POS option — permits enrollees to seek care from out-of-network providers.

The Healthy New York program was launched in 2000 as part of the state's Health Care Reform Act legislation (HCRA 2000). HMOs were required to offer eligible individuals, sole proprietors, and small groups a streamlined HMO package lacking certain benefits required in the Direct Pay and Small Group markets. Premiums are based on the combined costs of the three eligible populations, rather than on each group's claims experience, and the state subsidizes premiums through a reinsurance mechanism.

Risk Mitigation Programs

New York State has in place several risk mitigation programs to stabilize premiums in the Small Group, Healthy New York, and Direct Pay markets. The first is a market stabilization program, known as Regulation 146, for the Small Group and Direct Pay markets. Authorized as part of the Community Rating and Open Enrollment law of 1992, and implemented in 1993, the program has operated intermittently since then and has been amended five times to date, the most recent change taking effect in 2007.

Since these market segments are community rated, this program is designed to pool high-cost risks across insurance carriers. For example, if Carrier A had a lower proportion of high-cost claimants than the market average in a particular region, it would be required to pay into a pool. If Carrier B had a *higher* proportion of high-cost claimants than the market average in the region, it would receive a subsidy from the pool. These contributions and subsidies would eventually be reflected in the premium rates of each carrier. Since this regulation combines the claims experience of both the Small Group and Direct Pay markets in a common risk pool, there is an implicit cross-subsidization that occurs between these segments.

A second program is the Direct Payment Market Stop Loss Relief Program, a reinsurance program for the Direct Pay market, funded by the state. In 2006 the program had $40 million in funding. A third risk mitigation program is State Funded Stop Loss Relief for the Healthy New York Program, also supported by the state through HCRA. The 2006 funding amount for this program was approximately $92 million.

These latter two programs provide "stop-loss" payments to health plans to offset a portion of their claims costs for individuals whose medical costs in a given year fall within a specified "corridor." Under the Direct Pay stop-loss program, health plans are eligible for claims reimbursement for 90 percent of an individual's claims between $20,000 and $100,000 annually. The Healthy New York stop-loss program reimburses 90 percent of claims starting at a much lower threshold — $5,000 — up to a total of $75,000. These payments are used to reduce the overall premium costs to enrollees. State Insurance Department officials estimate that, given current funding, the Direct Pay stop-loss program reimburses only about one-third of eligible claims, while the Healthy New York stop-loss program reimburses health plans for all eligible claims.

Data Analysis

Market Share

For this analysis, we have separated the Direct Pay market into two populations. The first consists of those enrolled in HMO/POS products subject to community rating. Within this group are members enrolled in the plans standardized by the 1995 Point of Service law, as well as members enrolled in the earlier non-standardized plans grandfathered in under that

law. Based on plans' Annual Statements and the Regulation 146 database, we estimated that approximately 80,000 people were Direct Pay members at some point during 2006. According to the state Insurance Department, however, that number dropped significantly over the year; with additional data, we now estimate Direct Pay HMO/POS membership at year-end 2006 to be approximately 57,000, with some 88 percent of those members enrolled in the two standardized products created in 1995.

The second Direct Pay market component is the population enrolled in *non*-HMO/POS individual products that were also grandfathered in under the 1995 law and are also subject to community rating. Again based on input from the Insurance Department, we estimate this enrollment to be approximately 38,800 members as of year-end 2006. Not considered in this analysis is a third segment of the Direct Pay market, not subject to the community rating laws; the size of this population is unknown.

As of year-end 2006, we estimate 1.8 million Small Group market members, and approximately 132,000 Healthy New York members.

Table 2: **Market Segment Membership Estimates**

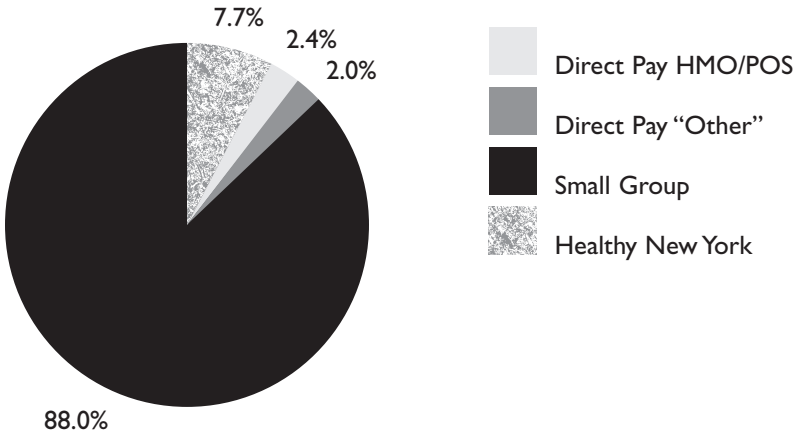
Population	Dec. 31, 2006	Dec. 31, 2007
Direct Pay HMO/POS	57,000	45,600
Direct Pay "Other"	38,800	38,500
Small Group	1,800,000	1,700,000
Healthy New York	132,000	148,000
Total	2,027,800	1,932,100

Source: Gorman Actuarial estimates based on HMO Annual Statements, the Regulation 146 database, the Healthy New York annual report, and discussions with the state Insurance Department

To estimate enrollments at year-end 2007, we reviewed membership trends in the HMO/POS market, observing a 15 percent to 20 percent decline in the Direct Pay group and a more modest decline in the Small Group market. We also obtained membership data for the Healthy New York market as of September 2007. Our resulting estimates total enrollment for all market segments of 1.9 million, with Direct Pay membership of approximately 78,000 (Table 2).

Figure 1 highlights the market share of each of the three market segments analyzed. As shown, the Direct Pay market represents

Figure 1: **Market Share Distribution, December 31, 2007**



Source: Gorman Actuarial estimates based on HMO Annual Statements, the Regulation 146 database, the Healthy New York annual report, and discussions with the state Insurance Department

approximately 4.4 percent of the total, and the Small Group market represents nearly 90 percent. Interestingly, the Healthy New York market share is much higher than the Direct Pay market share, although more than half of Healthy New York enrollment represents individual enrollees.

Plan Design

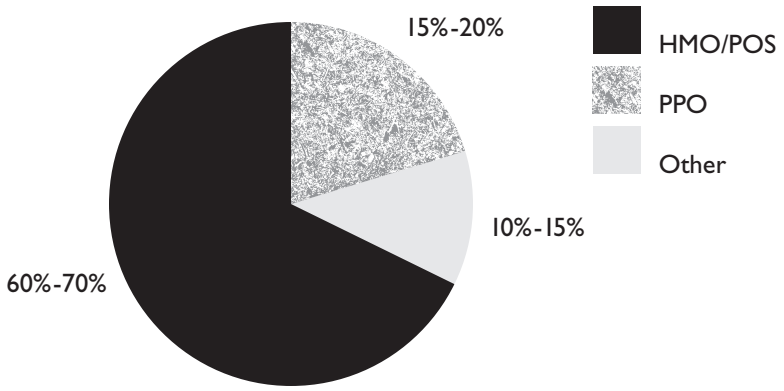
As described above, we have separated the Direct Pay market into two populations, the first of them consisting of individuals enrolled in HMOs or POS plans. Under the 1995 Point of Service law, New York State standardized the benefits to be offered by all health maintenance organizations issuing Direct Pay policies from 1996 on. Policies sold prior to 1996 were grandfathered in, and individuals could maintain their existing benefits. This first group of Direct Pay enrollees, then, includes individuals with either standardized or non-standardized HMO/POS coverage. Our assumption, though, is that the majority are enrolled in a standardized plan, whether an HMO or POS.

For both types, member cost-sharing includes a $15 office visit co-pay, a $500 inpatient visit co-pay, a $50 Emergency Department co-pay, and a $75 outpatient surgery co-pay. In addition, members are charged 20 percent of surgical costs, up to $200 per year. Finally, the pharmacy benefit includes a $5 co-pay for generics and a $10 co-pay for brand-name drugs, with a $100 annual deductible.

The second Direct Pay market population is made up of those enrolled in non-HMO/POS products. Our assumption is that these plans are similar to those of the Small Group non-HMO/POS market, as described below.

The Small Group market offers a broad range of plans, with an estimated 60 percent to 70 percent of the market enrolled in an HMO or POS product, 15 percent to 20 percent in a PPO product, and 10 percent to 15 percent in other product designs (Figure 2). For HMO/POS products, we estimate members' average cost-sharing as $20 for primary care office visit co-pays, $28 for specialist office visit co-pays, $275 for inpatient visit co-pays, $72 for Emergency Department co-pays, and $63 for outpatient surgery co-pays. The pharmacy benefit includes a $10 co-pay for generics, $25 co-pay for branded drugs in the formulary, and $50 co-pay for non-formulary drugs. The "Other" category represents a hodgepodge of

Figure 2: **Small Group Market Share**



Source: Gorman Actuarial estimates based on the Small Group Plan Design Survey administered by the state Insurance Department

Table 3: **HMO/POS Cost-Sharing Comparison**

	Average Plan Design		
	Small Group HMO/POS	**Direct Pay HMO/POS**	**Healthy New York HMO**
Inpatient Co-pay	$ 275	$ 500	$ 500
PCP Office Visit Co-pay	$ 20	$ 15	$ 20
Specialist Co-pay	$ 28	$ 15	$ 20
ED Co-pay	$ 72	$ 50	$ 50
Outpatient Surgery Co-pay	$ 63	$ 75	$ 75
Surgery: 20% Co-pay up to $200	N	Y	Y
Mental Health/Substance Abuse	Y	Y	N
Chiropractic, Ambulance, Durable Medical Equipment	Y	Y	N
Pharmacy			
Generic	$ 10	$ 5	$ 10
Brand	$ 25	$ 10	$ 20
Non-formulary	$ 50	$ 10	$ 20
Deductibles	None	$ 100	$ 100
Benefit Maximum	None	None	$ 3,000
Estimated Actuarial Value	**87%**	**92%**	**77%**

Source: Small Group Plan Design Survey administered by the state Insurance Department, Direct Pay laws and regulations, 2007 Healthy New York annual report, and Gorman Actuarial estimates

various kinds of indemnity coverage, and more limited benefit policies such as hospital-only coverage.

The entire Healthy New York population is enrolled in HMO products with cost-sharing similar to that of the Direct Pay population. There are some differences, however. For Healthy New York enrollees, physician office visit co-pays are higher, at $20. Less generous, too, is the pharmacy benefit, which includes a $100 annual deductible, and a $10 generic and $20 brand-name co-pay. Additionally, there is a $3,000 annual pharmacy benefit maximum. Finally, if there is a generic equivalent, in addition to the co-pay the member must pay the difference between the cost of the brand-name and generic drugs. While state Insurance Department regulations have added benefits to the Healthy New York package in recent years, several of those mandated in the Direct Pay and Small Group markets are not included, such as mental health and substance abuse treatment, chiropractic services, hospice, ambulance, and durable medical equipment.

Table 3 outlines the cost-sharing elements of the Small Group, Direct Pay, and Healthy New York markets for the HMO/ POS populations. As shown, the Direct Pay market appears to have the most comprehensive plan design, based on our estimates of the actuarial value of the plan designs in each market — that is, the percentage of claims that is the responsibility of the insurer. We have estimated the actuarial value of the HMO/ POS Small Group market to be 87 percent. In other words, 87 percent of benefits will be paid by the insurer and 13 percent of benefits will be paid by the member. In this analysis, the Direct Pay benefit structure is approximately

5 percent richer than that of the Small Group market and 15 percent richer than Healthy New York's.

Much of that difference is driven by the Direct Pay market's lower co-pays for physician office visits and prescription drugs. But another factor is the state regulations that limit the ability of HMOs in all markets to create benefit packages that include deductibles. With the exception of a small number of policies covering only hospital benefits, Direct Pay and Healthy New York products are HMO-based, and thus these markets' populations are not able to purchase benefit designs with the cost-sharing features found in the Small Group market. (A Healthy New York Health Savings Account-eligible product is the exception.) For the Direct Pay market, the inability of health plans to offer less comprehensive products at lower price points — products that attract a healthier risk pool — has created a type of self-selection that contributes to the deterioration of the market sector.

Table 4: **"Other" and PPO Cost-Sharing Comparison**

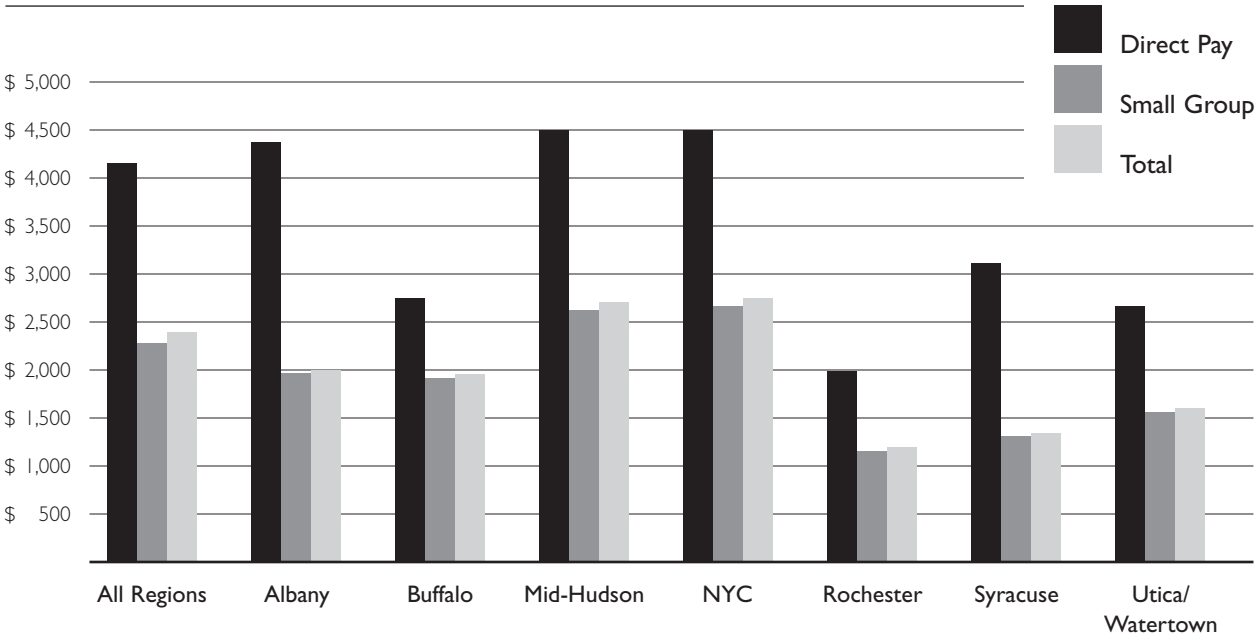
	Average Plan Design	
	Small Group and Direct Pay "Other"	**Small Group PPO**
Deductible	$ 300	$ 700
Co-insurance	30%	15%
Out-of-Pocket Maximum	$ 3,000	$ 1,500
Pharmacy		
Generic	$ 10	$ 10
Brand	$ 25	$ 25
Non-formulary	$ 50	$ 50
Actuarial Value	**74%**	**78%**

Source: Small Group Plan Design Survey administered by the state Insurance Department, and Gorman Actuarial estimates

We also compared the average value of Small Group PPOs and Small Group and Direct Pay "Other" plan designs. As shown in Table 4, the actuarial values of "Other" plan designs and of Small Group PPOs are 74 percent and 78 percent respectively.

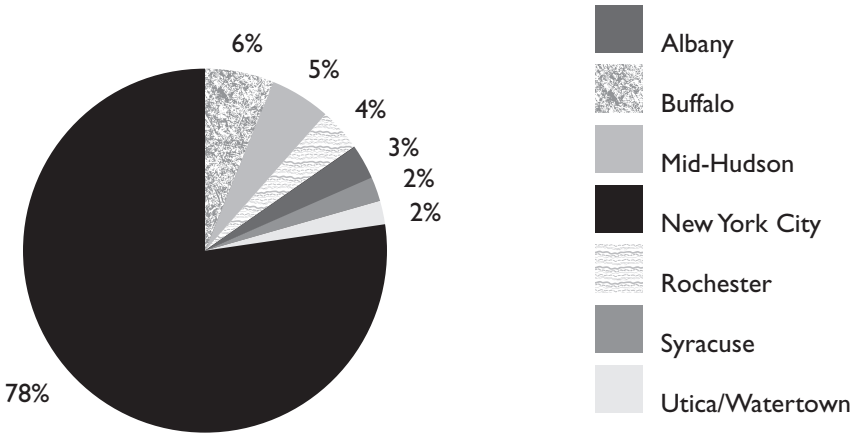
When we look at the Small Group market

Figure 3: **Annual Cost per Member, by Region**



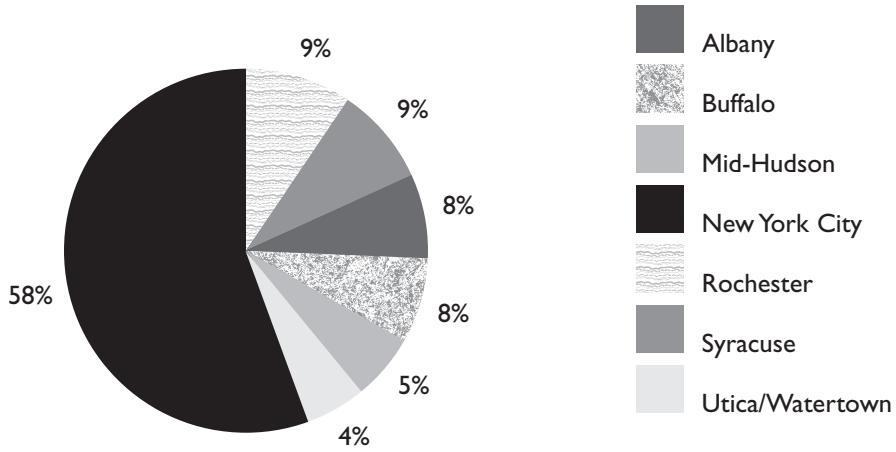
Source: Regulation 146 Database

Figure 4: **Direct Pay Member Distribution, by Region**



Note: Includes HMO/POS and "Other" Direct Pay
Source: Regulation 146 Database

Figure 5: **Small Group Member Distribution, by Region**



Source: Regulation 146 Database

in its entirety (including HMO/POS, PPO, and "Other" products), we estimate the overall actuarial value to be 84 percent. Interestingly, that is also the estimated value of the Direct Pay market as a whole.

Regional Analysis

Our comparison of annual cost per member by region (Figure 3) assumes that plan design and age distribution are consistent across the state. As shown, costs are highest in New York City and the Mid-Hudson region, and lowest in the Rochester and Syracuse areas.

Clear differences exist, also, in the distribution of the Direct Pay and Small Group markets' populations. As shown in Figures 4 and 5, 78 percent of the Direct Pay population, compared with 58 percent of the Small Group population, is in New York City, the costliest region. At the same time, 8 percent of the Direct Pay population,

versus 17 percent of the Small Group's, is in the lower-cost regions of Buffalo and Syracuse. Due to those differences in regional distribution, we estimate that overall claims costs for the Direct Pay market are 10 percent higher than for the Small Group market.

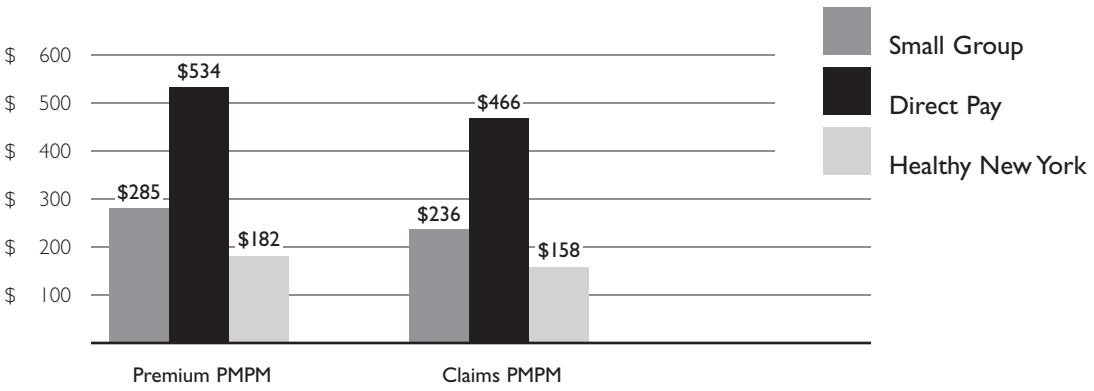
Financial Analysis

For Figure 6 and Table 5, we have limited our financial analysis to the HMO/POS populations (HMOs only, in the Healthy New York market, which does not offer POS plans). All information is based on the required Annual HMO Financial Statements; reported claims costs in those Statements may reflect cross-subsidies between the Direct Pay and Small Group markets, due to Regulation 146, reinsurance recoveries due to the Direct Pay and Healthy New York stop-loss funds, and premium deficiencies. We would also like to note that we believe the Healthy New York reported reinsurance recoveries may be understated, perhaps because of late receipt of recoveries or because they were attributed elsewhere, which would yield overstated claims expense and understated profit margin.

As shown in Figure 6, reported 2006 Direct Pay claims and premiums calculated for each member for each month covered under the policy (per member per month, or PMPM) are nearly two times higher than those of the Small Group market. Reported claims and premium PMPMs for the Healthy New York population are approximately 70 percent lower than the Direct Pay market's.

Table 5 shows some key statistics for the three populations — medical loss ratio (MLR), expense ratio, and profit margin.

Figure 6: **HMO/POS Reported Claims and Premiums**



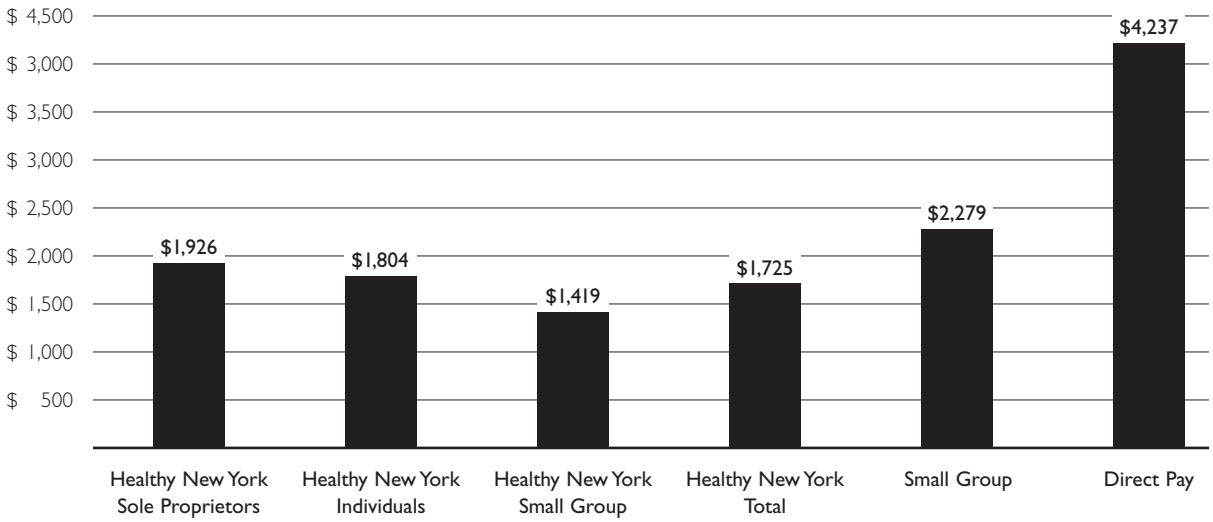
Note: PMPM = per member per month
Source: Annual HMO financial statements

Table 5: **HMO/POS Key Financial Statistics**

Market Segment	Medical Loss Ratio	Expense Ratio	Profit Margin
Small Group	82.9%	12.5%	4.6%
Direct Pay	87.2%	7.4%	5.4%
Healthy New York	86.9%	13.2%	-0.2%

Source: Annual HMO financial statements

Figure 7: **Average Claims Costs per Member per Year**



Source: Regulation 146 database and Healthy New York 2006 stop-loss report provided by the state Insurance Department

Medical loss ratio — total medical and pharmacy claims divided by total premium — is 83 percent for the Small Group population and 87 percent for the Direct Pay and Healthy New York markets. That is, 83 percent of the Small Group market's collected premiums in 2006 went towards paying for total claims expense; 17 percent was left to cover administrative expenses and profit.

We found the expense ratio — total administrative expenses divided by total premium — to be lowest for the Direct Pay market, probably due to the high premium rates in that sector. Notably, we found profit margin — the percentage of premium that is profit — to be reported at 5.4 percent for the Direct Pay market, higher than that of the Small Group market. This may be due primarily to the Direct Pay market's low expense ratio.

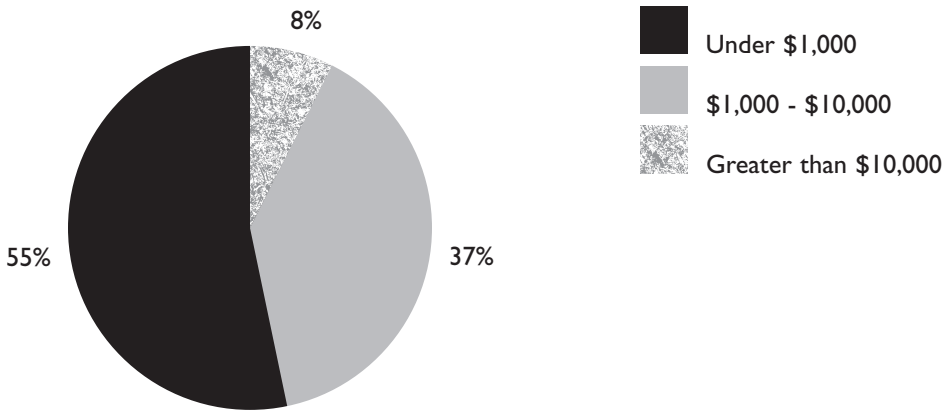
Using other data sources we also analyzed claims costs for the various markets (Figure 7). The Direct Pay population incurs the highest costs, and therefore has the highest morbidity, while the Healthy New York population has the lowest costs. It is interesting that the highest costs within the Healthy New York population are attributed to the sole proprietors.

Claims Distribution Analysis

Claims distributions were reviewed for all three market sectors. These distributions allow us to understand the impact of high-cost claimants on each of those sectors. As expected, the Direct Pay market has a higher proportion of high-cost claimants than does the Small Group market (Figures 8 and 9). For example, 8 percent of Direct Pay members, versus 4 percent of Small Group members, had claims greater than $10,000 in 2006. The Healthy New York market, meanwhile, has a lower proportion of high-cost claimants than either of the other markets (Figure 10).

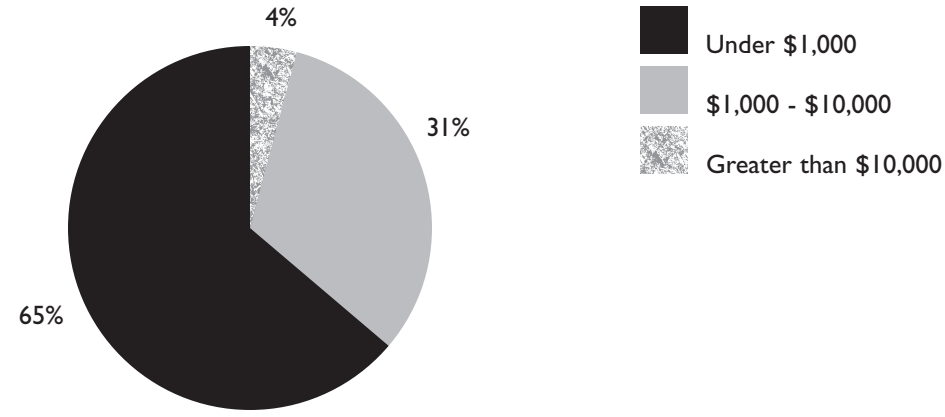
A further analysis of members incurring claims greater than $10,000 in 2006 shows

Figure 8: **Annual Claims Distribution by Cost, Direct Pay Market**



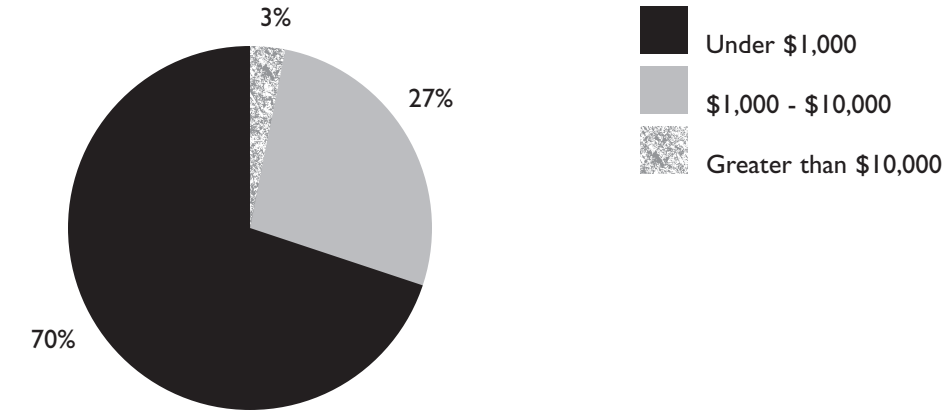
Source: Regulation 146 Database

Figure 9: **Annual Claims Distribution by Cost, Small Group Market**



Source: Regulation 146 Database

Figure 10: **Annual Claims Distribution by Cost, Healthy New York Market**



Source: Healthy New York 2006 stop-loss report provided by the state Insurance Department

the cost per claimant in the Direct Pay market to be 15 percent higher than in the Small Group market (Figure 11). This leads us to conclude that there are more high-cost claimants with a greater intensity of claims in the Direct Pay market. In the Healthy New York market, the average cost per high-cost claimant is lower than in the Small Group market.

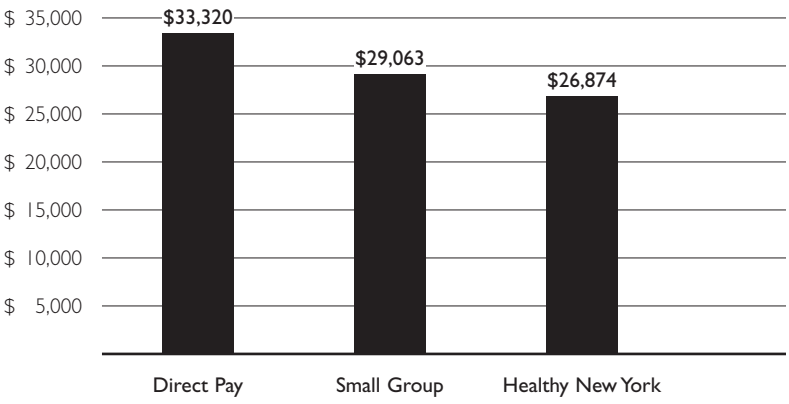
Risk Mitigation Analysis

As described previously, New York State has three risk mitigation programs related to the Small Group, Direct Pay, and Healthy New York markets. We have estimated the impact of these programs on each market segment for 2006. It is our understanding that during that calendar year, there were no Regulation 146 payments or subsidies. But, with the assistance of the Insurance Department, we were able to determine what the payments and subsidies would have been had Regulation 146 been in effect at that time.

Table 6 illustrates the estimated total dollar impact on each market segment resulting from the various risk mitigation programs. As shown, the result of Regulation 146 is that the Small Group market subsidizes the Direct Pay market by approximately $47.5 million. The state funds the Direct Pay market's stop-loss program at $40 million and the Healthy New York Program at $92.4 million.

Table 7 illustrates the estimated impact of the risk mitigation programs on premiums for each market segment. We estimate that current Small Group premiums are increased 1 percent, Direct Pay premiums are reduced 14.6 percent, and Healthy New York premiums are reduced 28.5 percent as a result of these programs.

Figure 11: **High-Cost Claims Averages by Market**



Note: Average cost of claims for members with more than $10,000 in claims, calendar year 2006

Source: Regulation 146 database and the Healthy New York 2006 stop-loss report provided by the state Insurance Department

Table 6: **Risk Mitigation Subsidies and Payout**

	2006 Total Dollar Impact in Millions			
	Small Group	**Direct Pay**	**Healthy New York**	**Total State Funding**
Projected Regulation 146	$47.5M	-$47.5M		$0.0
Direct Pay Stop-Loss		-$40.0M		-$40.0M
Healthy New York			-$92.4M	-$92.4M
Total by Market Segment	**$47.5M**	**-$87.5M**	**-$92.4M**	**-$132.4M**

Source: Regulation 146 analysis provided by the state Insurance Department, and the 2007 Healthy New York annual report

Table 7: **Premium Impact of Subsidies and Payout**

	2006 Premium Impact		
	Small Group	**Direct Pay**	**Healthy New York**
Projected Regulation 146	1.0%	-8.5%	
Direct Pay Stop-Loss		-7.3%	
Healthy New York			-28.5%
Total Premium Impact	**1.0%**	**-14.6%**	**-28.5%**

Source: Gorman Actuarial estimates

Data Modeling

Merged Market Analysis

Because we are dealing with three market segments, with varying risk mitigation programs, we have modeled three different merged market scenarios. In all of them, because there is no outside state funding for Regulation 146, we assume the net impact of this risk mitigation program would be zero. We also assume that all members in the merged market would maintain their current benefit levels.

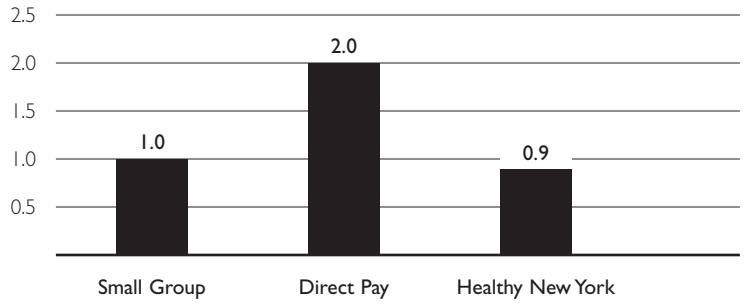
- **Scenario 1: Impact to premium in Year 1 of merging the Small Group and Direct Pay markets.** Under this scenario, we consider the merged market as the Small Group and Direct Pay markets only. We do not include the Healthy New York market in the definition of the merged market. Also, we assume the funding from the Direct Pay market's stop-loss program will be spread across the merged market.

- **Scenario 2: Impact to premium in Year 1 of merging the Small Group, Direct Pay, and Healthy New York markets.** Under this scenario, we assume that funding for the Direct Pay and Healthy New York stop-loss programs will be spread across the merged market.

- **Scenario 3: Impact to premium in Year 1 of merging the Small Group, Direct Pay, and Healthy New York markets.** Under this scenario we assume that funding for the Direct Pay stop-loss program will be spread across the merged market. Funding for the Healthy New York stop-loss program will only be directed to the Healthy New York population after the markets are merged.

In modeling these three scenarios, we based our market share, plan design, and regional assumptions on the results shown earlier in this report. After reviewing claims costs, risk mitigation programs, plan designs, and regional distributions, we determined morbidity assumptions for the three populations, as shown in Figure 12. Using a Small Group market morbidity assumption of 1.00, we determined that the Direct Pay market's risk profile is approximately two times that of the Small Group market. Originally, we had determined a range of 1.85 – 2.0 for the Direct Pay morbidity assumptions. Given the assumption of a significant drop in membership in 2007,

Figure 12: **Morbidity Assumptions**



Source: Gorman Actuarial estimates

however, we have assumed a morbidity at the high end of our range. This is due to the assumption that healthier individuals exit the market first, leaving those with higher morbidity within the market. We have also determined that the Healthy New York market is approximately 10 percent healthier than the Small Group market.

Assuming that, in Year 1 of the merger, most of the current Direct Pay members stay enrolled in their current plan design, and based on the community rating laws, which allow carriers to create different rating pools within each market, we have estimated that some 15 percent to 20 percent of the Small Group market will not be affected at all by the merging of the markets. This portion of the Small Group market will not be required to merge with the Direct Pay and/or Healthy New York populations, since it is marketed under policy forms that differ from the prevailing HMO/POS designs in the Direct Pay market.

Table 8 shows the results of Scenario 1, which merges the Small Group and Direct Pay markets only. In this scenario, Small Group market rates will increase 3.1 percent and Direct Pay market rates will decrease 37.2 percent.

In Scenario 2, which merges the Small Group, Direct Pay, and Healthy New York markets, Healthy New York market premium rates increase 43.7 percent, while Small Group market rates increase only 0.6 percent, as shown in Table 9. There are two reasons for this effect. The first is that we believe the Healthy New York population to be healthier than the Small Group and Direct Pay markets, so that it ends up subsidizing those populations when the markets are merged. The second reason is that the $92.4 million subsidy that was once directed entirely to the Healthy New York population is now spread across all three populations.

Scenario 3, which also merges the Small Group, Direct Pay, and Healthy New York markets, directs the Healthy New York subsidy of $92.4 million only to the Healthy New York market. As a result, Healthy New York rates increase 16 percent, due to that market's relatively better morbidity (Table 10).

Table 8: **Merged Market Analysis, Scenario 1**

Market Segment	Premium Rate Change	Estimated Enrollment Dec. 31, 2007
Small Group Market	3.1%	1,700,000
Direct Pay Market	-37.2%	84,100

Source: Gorman Actuarial estimates

Table 9: **Merged Market Analysis, Scenario 2**

Market Segment	Premium Rate Change	Estimated Enrollment Dec. 31, 2007
Small Group Market	0.6%	1,700,000
Direct Pay Market	-38.4%	84,100
Healthy New York Market	43.7%	148,000

Source: Gorman Actuarial estimates

Table 10: **Merged Market Analysis, Scenario 3**

Market Segment	Premium Rate Change	Estimated Enrollment Dec. 31, 2007
Small Group Market	2.2%	1,700,000
Direct Pay Market	-37.6%	84,100
Healthy New York Market	16.1%	148,000

Source: Gorman Actuarial estimates

Group Size Adjustment

One possible health reform policy that would temper the Small Group market rate increase resulting from a market merger would be the introduction of a group size adjustment for "groups of one." This would allow health

insurers to add a premium surcharge for these "groups" to offset the Small Group premium increases. New York State currently allows a 15 percent surcharge for sole proprietors obtaining insurance through the Small Group market.[6]

Based on modeling we have performed in other states, we assumed that sole proprietors represent 10 percent of current Small Group market enrollment. We also modeled the impact of the group size adjustment on Scenario 1, in which the merged market represents the Direct Pay and Small Group markets only. Finally, we modeled the impact of a range of group size adjustments, surcharges of 10, 15, and 20 percent. As shown in Table 11, introducing a group size adjustment of 15 percent to groups of one would reduce the rate increase for the Small Group market as a whole by approximately 0.7 percent, from 3.1 percent to 2.4 percent.

Reinsurance Modeling

Along with estimating the impact of merging the various markets, we modeled the funding required for a reinsurance program to eliminate the premium increase to the Small Group market. For this modeling exercise, we again applied Scenario 1, under which we assume that the merged market includes the Direct Pay and Small Group markets, and that funding for the Direct Pay stop-loss program will be spread across the merged market. Again, Regulation 146 will have no impact on the merged market. We also assumed a 15 percent surcharge on all groups of one. Based on these assumptions, the

6 New York State Insurance Law Section 4317(f)(2)

Table 11: **Impact of Group Size Adjustment**

Scenario 1		Premium Rate Change		
Market Segment	Original Premium Rate Change	Impact of 10% GSA	Impact of 15% GSA	Impact of 20% GSA
Small Group Market	3.1%	2.6%	2.4%	2.2%
Direct Pay Market	-37.2%	-30.9%	-28.3%	-25.6%

Note: GSA = group size adjustment

Source: Gorman Actuarial estimates

Table 12: **Reinsurance Funding**

Reinsurance Funding	Funding Requirement
Merged Market 2.4% Premium Reduction	$128M
Direct Pay Stop-Loss Program	$40M
Total	$168M

Source: Gorman Actuarial estimates based on the Regulation 146 database

Table 13: **Reinsurance Program**

Claims in Excess of AP1	Claims Less than AP2	% Reinsured	Reinsurance Dollars (in millions)
100,000	Infinity	50%	$ 160.3
150,000	Infinity	90%	$ 174.9
50,000	75,000	80%	$ 162.3
75,000	150,000	70%	$ 170.4

Note: AP1 represents the point at which claims would begin to be reinsured;
AP2 represents the point at which health plans would assume full responsibility for the claim.
Source: Gorman Actuarial estimates based on the Regulation 146 database

elimination of rate increases for the Small Group market would require a funding amount that would reduce all rates by 2.4 percent, as shown in Table 11. The total funding needed to merge the Small Group and Direct Pay markets without any premium impact on the Small Group market is shown in Table 12. Note that these funding requirements are based on 2006 dollars and would need to be adjusted for claims trends for future years. Assuming that $40 million is already reflected in the merged market, the $128 million that would be required to reduce rates by 2.4 percent means the total required funding for the merged market would be approximately $168 million.

The results of our modeling various reinsurance programs that would cost approximately $168 million are shown in Table 13. For example, in the merged market, reinsuring 50 percent of claims over $100,000 would cost the state approximately $160 million in Year 1. The state could also structure a corridor program similar to Healthy New York's, in which a health plan assumes initial responsibility for all claims, but a reinsurance program kicks in at a designated value as claims increase. To reinsure claims between $50,000 and $75,000 at 80 percent would cost the state approximately $162 million in Year 1; reinsuring claims between $75,000 and $150,000 at 70 percent would cost approximately $170 million in Year 1. In Table 13, "AP1" represents the point at which claims would begin to be reinsured, and "AP2" represents the point at which health plans would assume full responsibility for the claim. It is important to note that this would be an annual subsidy, and that the approximately $168 million required in the first year would increase each year on pace with claims trends.

New Membership and the Uninsured

As premium rates decrease for the Direct Pay market, we would expect to see some enrollment increases. Reducing price in the Direct Pay market has been shown to have a modest effect on demand, however, inducing only a small percentage of the uninsured to purchase coverage voluntarily. Many studies estimate an elasticity of demand of -0.3 to -0.7.[7] For this study, we have chosen an

7 Gorman B, D Gorman, E Kilbreth, T Bowe, G Nalli, R Diamond. 2007. *Reform Options for Maine's Individual Health Insurance Market.* Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy.

elasticity of demand of -0.5. What this means is that for every 10 percent decrease in price, existing Direct Pay membership would increase 5 percent.

Again, using results from Scenario 1, with a 15 percent surcharge for groups of one, we estimate that Direct Pay rates would decrease 28.3 percent (Table 11). Based on that decrease, we estimate that 11,700 new members would join the Direct Pay market in Year 1 of a merged market.

Literature on the health status of the uninsured relative to the current insured market is inconclusive. There is a belief, however, that the currently uninsured population is healthier than the currently insured; it is widely believed that individuals with serious and chronic health conditions will make any sacrifice necessary to maintain coverage and access to trusted health care providers. Due to this uncertainty, we have modeled a range of health status assumptions, and the corresponding impact on premiums, for the 11,700 new members. As shown in Table 14, premium increases in Year 2 range from 0.1 percent to 0.6 percent, with the higher premium increases assuming higher morbidity. We believe the impact of any newly insured — and presumably healthier — members will have a negligible impact on the overall pool of the merged market.

While we believe that new members may join the insured market due to the price decrease in the Direct Pay market, we also believe the modest price increase for the Small Group market would yield only a minimal change in membership. We believe this minimal shift in the overall Small Group market is due to three factors. First, this market segment has been experiencing significant premium increases, ranging from 8 to 12 percent, over the past five years, which would mask any modest increase due to the merger. Second, the Small Group market currently has many product choices, and rather than dropping coverage due to rate increases, employer groups could choose to offer a less rich plan design at the desired price point. Finally, merging the markets will affect each insurance carrier differently. As discussed earlier, the impact on some carriers' small group prices will be greater than on others'. Small employer groups could switch carriers in order to avoid a price increase.

Sensitivity Analyses

In our modeling we have produced a series of assumptions about the impact of merging markets. We believe the most sensitive of these are morbidity and market share. Since morbidity has an impact on claims costs, which in turn have an impact on overall premium rates, the higher the morbidity of the Direct Pay market the greater will be the impact on Small Group market premiums. By the same token, if the Direct Pay market share is a small proportion of the merged market, the premium impact on the Small Group market will be smaller.

Table 14: **Impact of Newly Insured Members, by Morbidity**

Health Status Assumptions	Premium Impact
20% higher morbidity than current Direct Pay	0.6%
10% higher morbidity than current Direct Pay	0.5%
10% lower morbidity than current Direct Pay	0.2%
20% lower morbidity than current Direct Pay	0.1%

Source: Gorman Actuarial estimates based on the Regulation 146 database

Table 15: **Impact by Enrollment Size**

Estimated Market Share	Membership as of Dec. 31, 2007 Original Enrollment Estimate: 20% disenrollment from year-end 2006	Enrollment Estimate 2: 30% disenrollment from year-end 2006	Enrollment Estimate 3: 37% disenrollment from year-end 2006
Direct Pay HMO/POS	45,600	39,900	35,910
Direct Pay "Other"	38,500	38,500	38,500
Small Group	1,700,000	1,700,000	1,700,000
Healthy New York	148,000	148,000	148,000
Total	1,932,100	1,926,400	1,922,410
Direct Pay Premium Impact with 15% GSA (Scenario 1)	-28.3%	-28.1%	-28.0%
Small Group Premium Impact with 15% GSA (Scenario 1)	2.4%	2.2%	2.1%

Note: GSA = group size adjustment

Source: Gorman Actuarial estimates

Table 16: **Funding Requirements, by Premium Levels**

Premium Reduction	(in millions) Funding Requirement	Direct Pay Subsidy	Total
3.5%	$ 161	$ 40	$ 201
2.5%	$ 134	$ 40	$ 174
2.0%	$ 107	$ 40	$ 147
1.5%	$ 80	$ 40	$ 120
1.0%	$ 54	$ 40	$ 94

Source: Gorman Actuarial estimates based on the Regulation 146 database

Based on our analyses, we feel confident with our morbidity assumptions. There has been a great deal of discussion, however, on the actual market share of the Direct Pay sector. Direct Pay membership has been declining steadily over the past few years, as noted in discussions with the state Insurance Department regarding evidence of a significant drop in 2007. We therefore modeled the impact of significant drops in Direct Pay HMO/POS membership to the overall merged market analysis, again focusing on Scenario 1, and assuming a 15 percent group size adjustment for groups of one.

Table 15 shows the results of our sensitivity analyses. The first column represents our original estimates, which reflect a 20 percent drop in Direct Pay HMO/POS membership from 2006. Enrollment Estimate 2 reflects an approximately 30 percent drop in Direct Pay HMO/POS membership, and Estimate 3 reflects a 37 percent drop. As expected, the Small Group premium impact decreases as Direct Pay enrollment drops. With 74,410

Direct Pay members in total, the Small Group market would experience a 2.1 percent premium increase, rather than the 2.4 percent increase with the 84,100 members of Enrollment Estimate 1.

Based on the above analyses, we also calculated funding requirements for various rate reductions in the merged market (Table 16). For a 2.0 percent merged market reduction, for example, the state would need to fund $107 million in addition to the original $40 million used for the Direct Pay market's stop-loss program, for a total of $147 million.

Conclusions

Our analysis of the Small Group and Direct Pay markets in New York provides evidence that the Direct Pay market has unfavorable morbidity when compared with the Small Group market. A merging of the populations would result in significant decreases in premiums (-26 percent to -38 percent) in the Direct Pay market, with modest premium increases (2 percent to 3 percent) in the Small Group market. These modest increases would be further reduced if a portion of the Direct Pay market were not eligible to merge with the Small Group market — those, for example, enrolled in products not offered in the Small Group market today. We have also modeled a few policy reforms to mitigate the Small Group rate increases. These reforms include the introduction of a group size adjustment for groups of one and a reinsurance program for the merged market.

Including Healthy New York enrollees in a merged market, our analyses show, would result in significant rate increases for that population. This is due to their favorable morbidity and the large state subsidy currently directed to the program each year.

For the Direct Pay market, however, another significant advantage of a market merger is that potential purchasers, as well as current enrollees, would have access to many more product options, some of which would be less comprehensive and thus available at a lower price point.

We estimate that reducing the premiums available to the Direct Pay market may entice approximately 11,700 new members to join the insured pool. Additionally, the introduction of new products may also bring new members into the insured pool. If the price point of new products is 20 percent to 30 percent lower than that of current Direct Pay products, the merged market may see an additional 11,700 new members join the pool, bringing the total new membership under this scenario to approximately 23,400. We also estimate that the addition of these new members to the insured pool would have a minimal impact on the premium rates of the merged market. Finally, the price reduction in the Direct Pay market may temper the number of members terminating coverage.

Absent an individual mandate, merging the Small Group and Direct Pay markets will result in only a modest growth in the insured pool. It would, however, provide significant rate relief for individuals, increase product options for individual purchasers, and stabilize the fragile Direct Pay market.

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ISBN 1-88127-7895