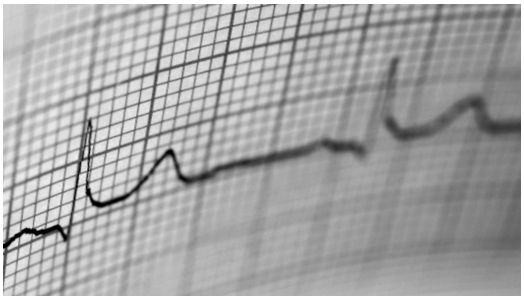
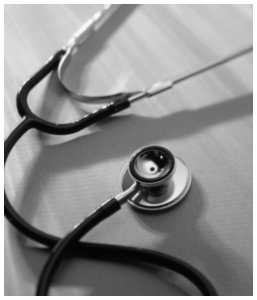
United Hospital Fund

Two into One: Merging Markets and Exchanges under the Affordable Care Act



A SPECIAL REPORT



United Hospital Fund

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

A Special Report from United Hospital Fund

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Two into One: Merging Markets and Exchanges under the Affordable Care Act

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Contents

Foreword

The Affordable Care Act gives states significant discretion in creating a new health benefit marketplace that best meets local needs. The law sets out minimum federal standards for the exchanges, but states can choose, for instance, to merge certain market segments into common risk pools. This report, the third in a series of exchange-related works undertaken this year with the support of the New York State Health Foundation, focuses on two such areas of state discretion involving "mergers": merging the individual and small business exchanges, and merging the individual and small group markets.

The first report in this series examined the key decisions state policymakers face in building the infrastructure for New York's health benefit exchange. We followed that work with an analysis of the challenges that lie ahead in coordinating Medicaid and the Exchange, an imperative under the ACA. This publication follows an earlier Fund report, *Merging the Markets* (2008), which focused on the premium impact of merging the individual and small group markets. We've again teamed up with Gorman Actuarial for this analysis, which involved a great deal more complexity and uncertainty than the earlier work, for a number of reasons. Decisions on a series of highly interconnected policy questions could affect enrollment in any number of ways. But the new market also will be shaped by the behavior of consumers and businesses confronting a mix of incentives and penalties, and the business decisions of health plans serving the markets.

As health reform implementation begins to move from the construction phase toward the "open for business" phase in 2014, the Fund will continue to explore the complex and intertwined decisions involved, pointing out both pitfalls and strategies for getting it right.

James R. Tallon, Jr.
President
United Hospital Fund

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Executive Summary

While the Affordable Care Act (ACA) lays out prescriptive minimum standards for state health benefit exchanges, it also gives states significant discretion on key policy issues. This paper focuses on two such discretionary decisions involving mergers: first, combining individual and small business exchanges, and second, merging the individual, or Direct Pay, and Small Group markets.

In analyzing the first question, we found that merging the exchanges is less about overall design than about organization. While establishing two separate exchanges for individuals and small employers would ensure a single-minded focus on small business needs, it would also entail considerable additional costs, duplication, and complexity, and would complicate the coordination necessary to serve both populations, particularly as the exchange evolves.

The second matter we examined — the prospect of merging the individual and Small Group markets — involves a great deal more complexity and uncertainty, due to ongoing federal regulatory guidance, state and federal policy discretion on key matters, and the behavioral questions facing individuals, health plans, and employer groups confronted by a complex federal regimen of subsidies, penalties, and incentives, superimposed on already complex state insurance markets.

We approached this analysis by distilling the market dynamics involved in a merger into three components: 1) merging the existing individual market with hundreds of thousands of new purchasers drawn by premium and cost-sharing subsidies and individual responsibility provisions; 2) merging this new market with the existing Small Group Market; and 3) merging this new individual/Small Group market yet again, with enrollees from employer groups with 51-100 employees, a market segment required under the ACA to be treated under Small Group rules by 2016.

Developing estimates on premium changes for these mergers required us to estimate the size and morbidity[1] of the current market and new membership likely to enroll in coverage as a result of the ACA. Health plan regulatory filings provided a good basis for these estimates for current membership, but the new membership side of the equation was considerably more complex, due to the unresolved policy questions, behavioral issues, and a lack of actual claims and enrollment data. We used census data to compile estimates of the size and morbidity of this new membership, and used ranges of enrollment and morbidity to develop estimates of premium change resulting from the mergers, measured through various scenarios. In developing estimates of premium changes, we attempted to isolate changes in what health plans would charge based on the mergers. These changes do not reflect differences in what individuals or employer groups would actually pay, which will vary based on available subsidies, products, employer contributions, and other variables. In addition, such variables as medical trend[2] and cost-sharing

1 "Morbidity" refers to the incidence of disease or rate of sickness among a particular population or in a specified geographic location.

2 "Trend" or "medical trend" is an essential component of pricing health insurance products and setting premiums. It is the year-to-year measurement of the increase or decrease in medical inflation due to the change in the cost of a medical service, multiplied by the rate of utilization or consumption of the service.

were not included in the analysis.

We found that significant cross-subsidization would occur through the merger of the existing individual market with new membership, producing significant premium reductions for individuals, ranging from 41 percent to 13 percent, depending on the size of market segments and morbidity differences. Merging this new individual market with the existing Small Group market would produce only marginally greater premium reductions for individuals. It is likely that more products would be available, and that slightly higher enrollment of individuals would follow, as would a concomitant decrease in federal subsidies. However, premiums would increase for Small Groups, by 3 percent to 13 percent, which could depress Small Group enrollment as employer groups drop coverage in the face of rising costs; this could also lead to increased cost sharing and reduced benefits for Small Group members.

Merging this new individual/Small Group market with nearly 1 million enrollees estimated to be in employer groups of 51-100 employees would only slightly reduce premiums for individuals and would slightly decrease the potential impact on Small Group members (the rise in premiums ranged from 2 to 9 percent).

These separate market merger analyses highlight the importance of morbidity factors when considering mergers. So long as a fairly narrow morbidity range is observed between the two populations to be merged, the size of the populations is of less consequence. Increasing the size of the population providing the cross-subsidy through its better health (i.e., lower morbidity rate) only marginally improves the premium change for the population receiving the cross-subsidy.

An alternative to merging the markets at the inception of New York's Exchange in 2014 would focus on making the new market first, putting off the question of whether to merge the markets until actual enrollment and morbidity data become available, along with more clarity on outstanding policy matters, behavioral responses by individuals, health plans, and small employers, and evolving market dynamics.

Introduction

While the Affordable Care Act lays out prescriptive minimum federal standards for new health benefit exchanges, it also gives states significant discretion on key policy issues. Two fundamental and intertwined areas of state discretion involve two "mergers": merging the operations of the individual and Small Employer Health Options Program (SHOP) exchanges, and merging the individual and Small Group markets so that premiums are based on the experience of both types of enrollees. These two prospective mergers are our subjects for this report.

In our research, we spoke to regulators, health plan officials, consumers, and business groups; surveyed relevant literature, statutes, and regulations; developed estimates of health status and current enrollment from health plan regulatory filings and data; and analyzed census data and other sources to estimate the health status and number of potential enrollees in the post-exchange market.

Our constant partner in this analysis was uncertainty. While the proposed rule issued by the U.S. Department of Health and Human Services (HHS) on July 11, 2011,[3] answers many questions, there are many factors and unknowns at play: extensive federal rulemaking yet to come; the discretion permitted state regulators and policymakers on a variety of matters, including exchange implementation legislation; and decisions that employer groups, individuals, and health plans will make under a complex new federal regimen of incentives and penalties superimposed on an already complex state insurance market.

Merging the Individual and SHOP Exchanges

The ACA requires states to establish an "American Health Benefit Exchange" that "facilitates the purchase of qualified health plans" by individuals and "provides for the establishment of a Small Business Health Options program" designed to assist small employers in facilitating enrollment of their employees in Small Group coverage.[4] But the law explicitly provides for the merger of individual and SHOP exchanges so long as the exchange has adequate resources to assist individuals and employers.[5]

The question of whether to maintain separate individual and SHOP exchanges can be viewed as both a design issue and an operational issue. Legislation could be adopted establishing separate exchanges with separate boards, governance structures, financing, and duties. But this option would increase costs in a variety of ways, create redundancies, complicate coordination and administration (particularly in areas of overlapping responsibility, such as individual and employer responsibility provisions and health plan and product approvals), confuse customers, and slow the evolution of the exchange in changing circumstances. None

3 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Proposed Rule. July 11, 2011. U.S. Department of Health and Human Services 45 CFR Parts 155 and 156, accessible online at http://www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf.

4 Affordable Care Act, Section 1311(b)(1).

5 Affordable Care Act, Section 1311(b)(2).

of the available literature we reviewed recommends adopting this two-exchange option.

Instead, it is more useful to view this question as an organizational challenge of creating and staffing an exchange that must serve customers with different needs. Certainly, the technology is readily available to route a small employer to a webpage or call center with services targeting small business purchasing decisions, and an individual to a different webpage or center that informs decisions on coverage options and determines eligibility for new subsidies, public programs, and the Exchange itself. The fear of an Exchange designed "top-down" to serve individuals without appropriate understanding of small employers was palpable at public forums on New York Exchange design[6] and in interviews with health plan executives and business leaders, who cautioned that the Small Group market is vastly different from the individual market.

Examples of these differences include premium collection, billing, and enrollment, but there are a wide variety of services that exchanges may consider to attract small businesses, including counseling on tax credit eligibility, insurance broker services, payroll administration, COBRA administration, premium aggregation from multiple health plans covering a single employer group, wellness programs, and additional products, such as life or disability insurance. "In sum," said one observer, "employers should be able to cede to the exchange most of the health insurance functions that would otherwise be handled by a human resources department or an external consultant."[7]

Exchange management that neglects small business membership does so at its peril; Small Group membership is a key focus of the ACA and a critical factor in the sustainability of an exchange. Enabling legislation that establishes a single exchange but restates and further delineates the obligations, services, and expectations of the SHOP to its small business clientele may alleviate some small business concerns; creating an organizational structure that incorporates a distinct SHOP component would as well, and would bolster an organization that may have to adapt to a changing market. The proposed HHS rule requires the SHOP exchanges, at a minimum, to offer an employer choice model under which businesses would designate a level of benefits, and employees would choose from among any health plan offering that coverage; states are also granted discretion to require exchanges to offer employers both more restrictive and more expansive variations on this model, such as allowing employees to pick any health plan at any benefit level.[8] Although the regulation solicits further comment on minimum participation rules that could limit the use of this model, if the model proves popular it will create a Small Group market akin to an individual market, better served by a single exchange. Over time, this method of purchasing could supplant the Small Group market as we know it today. Many observers believe this option is critical to serving "small" small businesses and attracting businesses from the non-Exchange market.

6 Health Insurance Exchange Options: Stakeholder Discussion, April 21, 2011, Albany, New York, convened by the Cuomo Administration; and Public Hearing: To examine the issues and challenges confronting New York State in its attempt to implement a State Health Insurance Exchange, New York State Senate Standing Committees on Health and Insurance, April 27, 2011.

7 Jost TS. July 2010. *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*. New York: The Commonwealth Fund.

8 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Proposed Rule, Part 155.705(b)(2) and (3).

Merging the Individual and Small Group Markets

The prospect of merging the individual and Small Group markets is a far more complex and multifaceted question than that of merging the exchanges. It would require health plans to develop premium rates based on the claims and administrative expenses of the combined individual and Small Group markets, rather than developing the rates separately for each group of enrollees. Health plans would also make all products available to individuals and Small Group members. This would represent a fundamental shift in how health plans price and market products. This rating methodology was once a staple of Blue Cross plan operations in New York;[9] reinstating it has been discussed intermittently in New York for the past 20 years, and it is the basis for rate-setting in the Healthy NY program. Interest has accelerated due to the continued deterioration of the individual market in New York, Massachusetts's merger of the two markets in July 2007, and the ACA's explicit authorization of states to undertake a merger.[10]

A 2008 United Hospital Fund report[11] reviewed the actuarial impact of merging the individual, Healthy NY, and Small Group Markets. That report was based on a database developed from health plan filings for reinsurance and risk adjustment mechanisms that yielded reliable enrollment and claims data for each market segment. It found that, in such a merger, average premiums for the Direct Pay market would decrease by 37 percent and Small Group market premiums would increase by 3 percent, but that results for individual health plans would vary from the average based on the relative risks of enrollees, a health plan's relative market share, and the type of license used.

Our current analysis is quite different from that in the 2008 report for a variety of reasons. First, in 2014 the individual market will be markedly different, with many new enrollees and a broader range of available products. Estimates vary on the number of currently uninsured individuals who will obtain coverage under the ACA. Second, no claims data are available on these potential new enrollees, so an analysis of the relative health status or morbidity of the new market entrants relies on self-reported data. Third, federal and state discretionary decisions could significantly affect enrollment. Fourth, individuals and businesses of all sizes, and health plans will face numerous decisions that arise from the blend of penalties and incentives for purchasing or not purchasing coverage contained in the ACA. These decisions are decidedly more complex than the ones individuals and businesses face today. As one health plan official noted, "This may sound funny coming from an insurance company, but we are intensely focused on behavior these days."

While modeling planned by New York State[12] will shed light on a number of these behavioral and policy variables, it is worth cataloguing some of the policy questions and statutory interpretations that will arise; a short list might include the following:

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

10 Affordable Care Act, Section 1312(c)(3).

11 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.

12 Agreement between the New York State Insurance Department and the Urban Institute, March 10, 2011.

Grandfathering. For our purposes, the most important — and vexing — requirement of the ACA is federal grandfathering provisions. One of the key underpinnings of the ACA is that it seeks to preserve the ability of consumers to "keep what you have now." Toward that end, the ACA allows consumers to renew current coverage under old rules.[13] New York has adopted similar provisions during times of sweeping reforms, in order to limit market disruption.[14] But to limit market segmentation, federal regulations[15] limit the changes health plans and plan sponsors can make to coverage and still retain their grandfathered status. In a similar vein, the ACA requires that participating health plans must pool the experience of individual exchange enrollees and non-exchange enrollees for individual premium rates, and Small Group exchange enrollees and non-exchange Small Group enrollees for Small Group premium rates,[16] but it appears to preclude the pooling of grandfathered enrollees with non-grandfathered enrollees.

Among all states in the nation, New York perhaps comes closest to the new federal standards scheduled to take effect in 2014: current coverage largely approximates what will be available on the Exchange, in terms of likely benefit provisions and rating and underwriting restrictions contained in the ACA, so maintaining grandfathered status offers less advantage in New York than it would in other states. Like provisions for a federal high-risk pool, grandfathering provisions are less relevant to New York, yet a literal reading of the statute would limit the amount of existing coverage that could be pooled with new coverage in or out of the exchange. Further complicating things, New York mandates participation by HMOs in certain products, and benefits and cost-sharing are defined in statute.

In guidance to health plans on regulatory filings, New York insurance regulators began tracking grandfathered and non-grandfathered coverage.[17] Federal regulators estimate that by 2014, about two-thirds of employer plans will relinquish their grandfathered coverage, and 40 to 67 percent of individual policies.[18] We assumed that while modest blocks of grandfathered coverage would remain in New York, additional federal rulemaking, individual, employer, and health plan decisions, or creative workarounds on the state level will lead to more abundant risk-pooling in New York of Exchange and non-Exchange products.

Healthy NY. A second discretionary decision involves the future of the Healthy NY program, offered to individuals and sole proprietors earning less than 250 percent of the federal poverty level (FPL), and to small business owners and employees under different income rules who receive a subsidy of roughly 30 percent of premium through a

13 Affordable Care Act, Section 1251.

14 For example, New York's Community Rating/Open Enrollment Law, Chapter 501 of the Laws of 1992, Section 21.

15 Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule, Thursday, June 17, 2010. Part II. Department of the Treasury, Internal Revenue Service, 26 CFR Parts 54 and 602; Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2590 Department of Health and Human Services 45 CFR Part 147.

16 Affordable Care Act, Section 1312(c) (1), (2) and (4).

17 New York State Insurance Department, PPACA Compliance Summary—New York Health. Accessible online at http://www.ins.state.ny.us/health/PPACA_chklist.pdf (accessed July 7, 2011).

18 Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule, Thursday, June 17, 2010. Part II. Department of the Treasury, Internal Revenue Service, 26 CFR Parts 54 and 602; Department of Labor, Employee Benefits Security Administration, 29 CFR Part 2590 Department of Health and Human Services 45 CFR Part 147.

$161 million appropriation for a marketwide stop-loss subsidy. For Healthy NY individuals and sole proprietors (94,798 of these members were enrolled in the first quarter of 2009), Exchange enrollment would likely be more attractive,[19] but the decision on whether to continue the program for Small Group enrollees is more complex. Since different eligibility standards are used, it is difficult to determine whether federal tax credit subsidies would replace Healthy NY stop-loss premium subsidies for all participating businesses, and federal IRS rules appear to allow both a federal tax credit and the existing stop-loss subsidy.[20]

Medicaid/Family Health Plus (FHP). After federal "maintenance of effort" provisions expire on December 31, 2013, New York will have to determine whether 138,000 current FHP enrollees[21] earning between 133 and 150 percent FPL will be able to continue their current coverage, enroll in a new Basic Health Program (if offered by the state), or obtain subsidized coverage through the exchange. Current enrollees in the Family Health Plus Employer Buy-In program, through which employer groups and union trusts can obtain coverage, may face transitions to subsidized individual coverage through the exchange as well. Decisions by policymakers — and individuals — on other programs, such as Medicaid Continuation Coverage Assistance, the AIDS Drug Assistance Program (ADAP), the Medicaid Third Party Payer program, FHP Premium Assistance, Medicaid Buy-in for the working disabled, Medicaid spend-down, and others, could also affect enrollment.

Basic Health Program (BHP). Under the ACA, states have the option of establishing a Basic Health Program[22] for subsidy-eligible enrollees with incomes between 133 and 200 percent FPL. Many observers have commented on the potential of the BHP to generate positive revenue for states, or enhanced payment rates for providers,[23] and to improve the affordability and continuity of care for lower-income individuals who would transition between Medicaid eligibility and eligibility for subsidized coverage though the Exchange. On the other hand, adoption of a BHP could significantly reduce enrollment in the Exchange, affecting its leverage with participating health plans and altering the risk profile of the market (positively or negatively), and could limit access to certain health care providers and products that might otherwise be available to consumers purchasing from the Exchange. A recent paper advocating

19 Based on our analysis of current premiums and cost-sharing provisions for individual and sole proprietor Healthy NY enrollees, compared to ACA subsidies to individuals with household incomes under 250 percent FPL, it appears that coverage through the Exchange would be more affordable for those eligible to purchase through the Exchange.

20 U.S. Treasury Department, Internal Revenue Service, Section 45R—Tax Credit For Employee Health Insurance Expenses of Small Employers, Notice 2010-44.

21 Personal communication, New York State Department of Health, May 20, 2011.

22 Affordable Care Act, Section 1331.

23 See, for example: Palmer J. April 2011. *Healthcare Reform and the Basic Health Program Option: Modeling Financial Feasibility.* Milliman Healthcare Reform Briefing Paper. Accessible at http://publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf (accessed July 7, 2011); Dorn S. March 2011. *The Basic Health Program Option under Federal Health Reform: Options for Consumers and States.* Urban Institute, prepared for State Coverage Initiatives, Robert Wood Johnson Foundation. Accessible at http://www.rwjf.org/coverage/product.jsp?id=72024 (accessed July 7, 2011); Mercer. July 2011. *State of California Financial Feasibility of a Basic Health Program,* funded by the California HealthCare Foundation. Accessible at http://www.chcf.org/publications/2011/07/california-financial-feasibility-bhp (accessed July 7, 2011); and Curtis R and E Neuschler. *Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach.* Institute for Health Policy Solutions, with support from the California HealthCare Foundation. Accessible at http://www.chcf.org/publications/2011/07/continuity-medical-enrollees-affordability-exchange (accessed July 7, 2011).

for the adoption of the BHP in New York State estimates enrollment of 467,000.[24]

Sole Proprietors and Associations. Enrollment data are lacking for sole proprietors and association group members. Under New York's complex laws, sole proprietors can access health coverage in multiple ways, through both individual and Small Group coverage. New HHS guidance, however, does not permit sole proprietors to purchase coverage through the SHOP exchange.[25] Some of this coverage might be grandfathered, but some might be discontinued by health plans. Association groups often consist of individuals, sometimes from a common occupation or profession, who are pooled together and charged a rate based on their claims experience rather than a community rate, if part of the group attains certain enrollment levels or is granted special status under the Insurance Law. Whether such arrangements will meet federal standards and continue to be offered by health plans is an open question. New federal subsidies and market choices for individuals may deprive association plans of their chief marketing advantage — the high cost and limited benefit options available for individuals. Sole proprietors and association group members, many of whom pay a membership or application fee or surcharges in addition to premiums, may find the standard market more appealing.

Rating. Of all states, New York comes perhaps the closest to conforming to the rating and underwriting restrictions contained in the ACA. New York has only to consider the introduction of tobacco use rating at a 1:1.5 ratio, and age rating up to a 3:1 ratio (i.e., older consumers may be charged as much as 300 percent more than younger consumers). Available subsidies would seem to limit some of the increased enrollment due to charging younger customers less, and additional enrollment of the young might be offset by decreases in older customers facing sharply higher premiums.

Reinsurance/Stop-Loss Programs. Certain Direct Pay products are subsidized through reinsurance and stop-loss mechanisms. A state "market stabilization" or reinsurance program for the standardized Direct Pay products (HMO and HMO/POS) provides a $39 million subsidy through an annual appropriation from the State Insurance Department budget, achieved through a stop-loss mechanism for high-cost claims. A second risk adjustment mechanism applicable to the Direct Pay and Small Group markets provided an additional $62 million in premium subsidies to the individual market in 2009. Healthy NY enrollee rates are subsidized through an annual $161 million appropriation for a stop-loss program. Small Group members also received a $47 million subsidy through the Regulation 146 stop-loss mechanism in 2009, and overall, Small Group members contributed a $62 million subsidy to individual policyholders through this same mechanism in their premiums in 2009 (see Appendix 1 for source of reinsurance and market stabilization fund estimates). How these programs are treated during reform implementation will have an impact on rates for individuals and small

24 Benjamin ER and A Slagle. June 2011. *Covering More New Yorkers While Easing the State's Budget Burden. Bridging the Gap: Exploring the Basic Health Insurance Option for New York*. Community Service Society. Accessible at http://www.nyshealthfoundation.org/userfiles/BHP2011-final-WEB.pdf (accessed July 7, 2011).

25 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. Proposed Rule, Executive Summary, p. 14.

employers, as will the design of three new risk mitigation mechanisms slated to be created under the ACA.[26]

Enrollment Periods. State Exchanges are charged with administering enrollment periods during which consumers will have to enroll in coverage.[27] Intended to discourage consumers from waiting for the onset of a health problem to purchase coverage, the initial open enrollment period proposed by HHS of October 1, 2013, to February 28, 2014, could limit enrollment, particularly if applied to the non-Exchange market as well. Currently, health plans in New York must accept applicants year round, and may only impose a pre-existing condition waiting period, if applicable,[28] but the ACA bans pre-existing condition waiting periods beginning in 2014.

Product Offerings. New York law limits the comprehensive coverage health plans can offer individuals to the standardized HMO/POS products. While ACA requirements that health plans offer "gold" and "bronze" coverage through the Exchange will override this requirement, it is not clear if the same standard will be applied to the non-Exchange market. Making a greater variety of products available in the non-Exchange market would likely increase overall enrollment, particularly among those ineligible to purchase through the Exchange, and also limit selection between the Exchange and non-Exchange markets. Federal determinations regarding essential health benefits, expected this fall, could also affect enrollment.

Key Components of a Market Merger Analysis

We structured the market merger analysis in three stages or steps. First, we considered the merger of the existing Direct Pay market (which includes the Healthy NY individual and sole proprietor populations) with the new market created for individuals through ACA subsidies, personal responsibility provisions, and new product offerings. This can also be viewed as a Direct Pay market expansion. Second, we considered the merger of the new individual market with the existing Small Group market. Third, we considered the merger of the newly combined Direct Pay/Small Group market with the current market segment of employer groups with 51-100 employees. In each case, we characterized the population and morbidity of the existing market based on health plan regulatory filings, and made estimates of the size and morbidity of the new market, based on census data and a set of assumptions based on market dynamics and consideration of future policy options. We arrived at "low-end" and "high-end" estimates of new membership, and used the same range of morbidity estimates for the new population. The methodology and data sources are described in detail in Appendix 1.

We then demonstrated possible premium changes for affected market segments, based on different scenarios. When multiple market segments are merged, the premium change estimates reflect the possible impact of combining these segments, compared to existing premiums for market segments. When evaluating the results of each option, the premium changes can be compared, but

26 Affordable Care Act, Sections 1341, 1342, and 1343, and Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. Proposed Rule, July 11, 2011. U.S. Department of Health and Human Services 45 CFR Part 153. Accessible online at http://www.ofr.gov/OFRUpload/OFRData/2011-17609_PI.pdf.

27 Affordable Care Act, Section 1311(c)(6), and Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans 45 CFR Part 155.410.

28 New York State Insurance Law, Section 4318.

not added. These premium changes were relative to what the insurer would charge and do not necessarily translate to what an individual or small employer would pay. These premium changes did not reflect employer contributions, premium and cost-sharing subsidies available through the Exchange to certain individuals and Small Groups, or existing state subsidies. In addition, they did not reflect the impact of medical trend, or the variance created by different cost-sharing features, including out-of-network benefit products. The premium changes illustrated here are intended to isolate what the impact of just merging the markets would do to premiums charged by health plans.

Current Individual Market

We identified 187,409 individuals purchasing coverage in New York, excluding Medicare supplement coverage.[29] This figure includes the high-cost, high-risk, standardized HMO and HMO/POS products[30] that often serve as a proxy for New York's entire individual market, Healthy NY coverage for individuals and sole proprietors, conversion policies, special coverage riders, basic hospital and basic medical coverage, and comprehensive coverage grandfathered under past reforms in New York. This estimate, as noted earlier, does not include individual sole proprietors enrolled under group coverage or association plan members. Of these 187,409 individuals, 94,798 were enrolled through Healthy NY, and 36,353 were enrolled in the standardized HMO/POS products. Although another 39,532 individuals were enrolled in a category that the Insurance Department terms "Other," we estimate that about 9,970 enrollees from this Other category have more comprehensive coverage that participates in the Regulation 146 risk adjustment mechanism. Much of this coverage has been in place for many years, so members may be enrolled in or eligible for enrollment in Medicare, and their New York coverage may be supplemental. Finally, there are currently 1,320 enrollees with designated medical conditions enrolled in the NY Bridge Plan, New York's temporary high-risk pool created under the ACA.[31] So in all, we estimate a current Direct Pay

29 New York State Insurance Department, Health Insurance Data Exhibit (HIDE). See Appendix 1 for more details. An Urban Institute analysis of 2009 American Community Survey data, May 2011, estimates that 4.1 percent of the 16,751,000 nonelderly New Yorkers are covered under health benefits "directly purchased" from an insurer. Estimates of individual purchasers, however, have long been the subject of discussion nationally and in New York on whether the Census data overcounts individual purchasers.

30 New York State Insurance Law, Sections 4321 and 4322.

31 For background, see website for NY Bridge Plan: http://www.ghi.com/nybridgeplan/preexisting_conditions.html (accessed July 7, 2011).

Table 1: **Estimate of Direct Pay Market Enrollment**

Type of Coverage	Enrollment
Standardized HMO	27,570
Standardized HMO/POS	8,780
Direct Pay "Other"	9,970
Healthy NY Individual and Sole Proprietor	94,800
NY Bridge Plan	1,320
Total	142,440

Source: Health Insurance Data Exhibit, 2009, New York State Insurance Department and other sources (see Appendix 1)

market of roughly 142,000 individuals (see Table 1) eligible to be pooled together with new Exchange enrollees. We estimate that these enrollees will demonstrate morbidity of 1.5 to 2.0 times that of the current Small Group market.

Although 53 carriers participated in the Direct Pay market in the first quarter of 2009, just three — Empire BCBS, Excellus BCBS, and Oxford Health Plans — represented 66 percent of the market.

New Individual Market

The new individual market will consist of grandfathered coverage and new coverage purchased by individuals with or without subsidies. People eligible for subsidies will gravitate toward the Exchange; ineligible people may purchase from either the Exchange or non-Exchange markets. Since individual market risks from the Exchange and non-Exchange markets will be pooled together for the purposes of setting rates under ACA provisions, whether enrollees purchase from the Exchange or not is not relevant to our analysis.

In order to determine a range of premium changes that would result from these market mergers, we created two estimates of potential new purchasers under the ACA, a low-end estimate of 438,000 individuals, and a high-end estimate of 691,000 newly insured. In developing these estimates, we examined figures on uninsurance for nonelderly individuals in New York among those ineligible for public programs, and considered such factors as citizenship, immigration status, and income, particularly for those who may be eligible for premium and cost-sharing subsidies under the ACA by virtue of income alone.

We estimate that this new group of enrollees would be healthier (would have lower morbidity) than current Direct Pay membership, but we incorporated different variations of morbidity in order to show a possible range of outcomes. Morbidity and enrollment estimates are discussed in detail in Appendix 1.

Merging markets requires health plans to develop premiums in a way that produces cross-subsidization between different market segments. Cross-subsidization is maximized for current individual subscribers when their market is merged with one that both has a significantly lower morbidity and is significantly larger. As the morbidity differences between the various market segments decrease, less cross-subsidization occurs. In addition, as the market share differences decrease, less cross-subsidization among markets occurs. See Appendix 2 for a fuller description of this dynamic.

As shown in Table 2, merging a new population of individuals (low-end estimate) with the existing Direct Pay market produced changes in premiums ranging from a 38

Table 2: **Merger of Existing Direct Pay Market with New Membership — Low-End Estimate**

			Scenario 1		Scenario 2		Scenario 3		Scenario 4	
	Enrollment	Market Share	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change
Direct Pay	142,000	25%	1.50	-25%	2.00	-38%	1.50	-13%	2.00	-28%
New Membership	438,000	75%	1.00		1.00		1.25		1.25	
New DP Market	581,000	100%								

Source: Gorman Actuarial estimates

percent reduction to a 13 percent reduction, depending on the morbidity of the enrollees. The largest premium change occurred when new membership with morbidity at 1.0 was combined with a Direct Pay population with a morbidity of 2.0.

For our high-end estimate, we assumed new membership of 691,000. With this greater enrollment (Table 3), slightly larger premium changes resulted, ranging from a 41 percent reduction to a 14 percent reduction. In this instance, the greater number of new enrollees offset the risk profile of the current market somewhat, but not as much as one might expect.

Table 3: **Merger of Existing Direct Pay Market with New Membership — High-End Estimate**

			Scenario 1		Scenario 2		Scenario 3		Scenario 4	
	Enrollment	Market Share	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change
Direct Pay	142,000	17%	1.50	-28%	2.00	-41%	1.50	-14%	2.00	-31%
New Membership	691,000	83%	1.00		1.00		1.25		1.25	
New DP Market	833,000	100%								

Source: Gorman Actuarial estimates

Current Small Group Market

In 2009, small businesses (2 to 50 employees) purchased coverage for about 1.6 million workers and dependents. Small groups typically purchase through agents or brokers, though some businesses purchase coverage through market facilitators such as HealthPass[32] or local chambers of commerce. A full range of product designs is available, with high-quality benefits. Through the ACA, small groups with higher proportions of low-wage workers became eligible for tax credits in 2010; these can reduce an employer's share of premiums by up to 35 percent.[33] There are broad estimates of the number of New York businesses potentially eligible for the credit, but we were unable to locate data on businesses actually claiming it, and whether it was used principally to subsidize existing coverage or to make new coverage offers feasible. In addition, the Regulation 146 risk adjustment mechanism provided $47 million in subsidies to small groups with a higher proportion of high-cost claims.

New Small Group Market

ACA provisions have a more modest impact on the Small Group market than on the individual market. Most existing small groups can purchase through the Exchange or non-Exchange markets, but enhanced tax credits will only be available for coverage through the Exchange. Employer responsibility provisions do not apply to groups of 50 or under. Some observers believe ACA provisions will induce a significant number of employer groups to drop coverage,[34] while others disagree.[35]

32 See http://www.healthpass.com/ for background on this organization.

33 ACA Section 1421.

34 Singhal S, J Stueland and D Ungerman. June 2011. How US Health Care Reform Will Affect Employee Benefits. *McKinsey Quarterly*. McKinsey & Company.

35 Garrett B and M Buettgens. January 2011. *Employer-Sponsored Insurance Under Health Reform: Reports of Its Demise Are Premature*. Princeton, NJ: Urban Institute for the Robert Wood Johnson Foundation; McMorrow S, L Blumberg and M Buettgens. June 2011. *The Effect of Health Reform on Small Businesses and Their Workers*. Princeton, NJ: Urban Institute for the Robert Wood Johnson Foundation.

At the same time, some analysts believe that the individual responsibility mandate could increase employer-sponsored coverage,[36] a result observed in post-reform Massachusetts.[37] If the Exchange accomplishes its mission, it may attract small businesses that find purchasing there convenient. A robust set of services related to "employee choice" plans could prove another potential source of growth, should state and federal policymakers take this direction.

Merging the Individual and Small Group Risk Pools

As seen in Table 4, merging the current Small Group market with our low-end assumption of the new Direct Pay market produced premium changes ranging from a 47 percent reduction for individuals to an 11 percent increase for Small Groups, based on various morbidity assumptions. Scenario 1, which assumed a morbidity of 1.0 for Small Group and new membership and a 1.5 morbidity for Direct Pay, produced the smallest Small Group premium increase (3 percent) and a 31 percent reduction in Direct Pay premiums. The relatively modest difference in premium changes between this merger and the merger of current Direct Pay and new membership highlights the significant impact of high-risk individuals on market premiums. If we assume the morbidity difference between current individual market purchasers and new enrollees and current Small Group members is 50 percent (i.e., a morbidity of 1.0 vs. 1.5), there would be a limit to how much cross-subsidization these market segments could provide, regardless of their size. While premium increases for Small Groups may be offset by enhanced federal tax credits for firms with lower-wage workers, other small firms may drop coverage as a result of the increases, or "buy down" the premium through higher deductibles, co-payments and co-insurance, more restrictive networks, or reduced benefits — all well-documented strategies that employer groups large and small use to offset annual premium increases. These increases would also come on top of normal increases in medical trend.

36 Eibner C et al. 2010. *Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses*. Sponsored by the U.S. Department of Labor. Technical Report. RAND Health. Santa Monica, CA.

37 Gabel JR et al. November 2008. After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage. *Health Affairs* 27: w566-575.

Table 4: **Merger of New Direct Pay Market with Small Group Market — Low-End Estimate**

			Scenario 1		Scenario 2		Scenario 3		Scenario 4	
	Enrollment	Market Share	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change
Direct Pay	142,000	6%	1.50	-31%	2.00	-47%	1.50	-28%	2.00	-44%
New Membership	438,000	20%	1.00		1.00		1.25		1.25	
Small Group	1,629,000	74%	1.00	3%	1.00	6%	1.00	8%	1.00	11%
New Merged Market	2,210,000	100%								

Source: Gorman Actuarial estimates

Table 5, which uses the high-end assumption, further illustrates this point, since it resulted in only slightly lower Direct Pay premiums and only a modest improvement in the impact on Small Group rates.

Table 5: **Merger of New Direct Pay Market with Small Group Market — High-End Estimate**

			Scenario 1		Scenario 2		Scenario 3		Scenario 4	
	Enrollment	Market Share	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change
Direct Pay	142,000	6%	1.50	-31%	2.00	-47%	1.50	-27%	2.00	-44%
New Membership	691,000	28%	1.00		1.00		1.25		1.25	
Small Group	1,629,000	66%	1.00	3%	1.00	6%	1.00	10%	1.00	13%
New Merged Market	2,462,000	100%								

Source: Gorman Actuarial estimates

Groups of 51-100 Employees

The ACA redefines Small Group size as 1 to 100 employees, but it allows states to delay implementation of the 51-100 employee group until 2016.[38] Although HMOs in New York must apply a Large Group community-rating methodology to groups of 51 and above, other licensees are permitted to use different rating methodologies. Though rating in this market is usually referred to as "experience rating," it typically blends "manual" or "book" rating (based on age, gender, and occupation) with a smaller portion of the rate determined by a group's claims experience.[39] Applying community rating to 51-100 employee groups — whether in 2014 or 2016 — will create winners and losers. Groups with more young workers, with more male workers, or in lower-risk occupations will experience significant rate increases; groups with older workers, with more women, or in higher-risk occupations will see rate decreases. Groups facing higher rate increases may consider self-funding, which is less common among smaller businesses than it is among larger employer groups, but not unheard of in New York's market;[40] nothing in the ACA prevents groups from switching to self-funded arrangements. Whatever decision is made on the timing of applying community rating to these groups, it is worth considering a process that gradually phases in full community rating over time by limiting the extent to which health plans can use age, gender, and experience rates towards an overall rate.

Health plans report enrollment in the 51-100 employee group market as part of their Large Group data, so separate enrollment numbers are not available. Based on averages from available federal and state labor surveys, ranges of offer and take-up rates, and a standard contract size of 2.1 covered lives,

38 Affordable Care Act, Section 1304 (b)(3).

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

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

we estimate that the Small Group market could grow by about 992,000 covered lives when community-rating rules are phased in. Employer responsibility provisions would apply to a segment of this market, which could either increase group enrollment or increase individual enrollment (i.e., if employer groups determine that it makes more sense to pay penalties than to continue to provide coverage).

In the final stage of our analysis, we merged current Direct Pay, new membership, current Small Group, and the 51-100 employee group market. As noted earlier, states have some discretion in when to prohibit experience rating for this segment, which is now considered part of the Large Group market. We assumed morbidity for this population that was roughly comparable to that of the Small Group population, though it might be slightly higher or slightly lower. In our low-end assumption (Table 6), merging these market segments produced the largest premium change (a 48 percent reduction) for Direct Pay members under Scenario 2, and the highest impact for 51-100 employee groups (an 8 percent increase) under Scenario 4, which assumed higher morbidity for new membership. Scenario 1 produced a 32 percent premium decrease for Direct Pay members and a 2 percent increase for both categories of Small Group members.

Table 6: **Merger of New Merged Market with 51-100 Employee Group Market — Low-End Estimate**

			Scenario 1		Scenario 2		Scenario 3		Scenario 4	
	Enrollment	Market Share	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change	Morbidity Assumption	Premium Change
Direct Pay	142,000	4%	1.50	-32%	2.00	-48%	1.50	-30%	2.00	-46%
New Membership	438,000	14%	1.00		1.00		1.25		1.25	
Small Group	1,629,000	51%	1.00	2%	1.00	4%	1.00	6%	1.00	8%
51-100 Employee Group	992,000	31%	1.00	2%	1.00	4%	1.00	6%	1.00	8%
New Merged Market	3,201,000	100%								

Source: Gorman Actuarial estimates

Table 7 shows the results of using the same morbidity assumptions for all four market segments, but increasing the new membership size to 691,000, which had little impact on either lower premiums for individuals or higher premiums for Small Groups or 51-100 employee groups.

Table 7: **Merger of New Merged Market with 51-100 Employee Group Market — High-End Estimate**

	Enrollment	Market Share	Scenario 1 Morbidity Assumption	Scenario 1 Premium Change	Scenario 2 Morbidity Assumption	Scenario 2 Premium Change	Scenario 3 Morbidity Assumption	Scenario 3 Premium Change	Scenario 4 Morbidity Assumption	Scenario 4 Premium Change
Direct Pay	142,000	4%	1.50	-32%	2.00	-48%	1.50	-29%	2.00	-45%
New Membership	691,000	20%	1.00		1.00		1.25		1.25	
Small Group	1,629,000	47%	1.00	2%	1.00	4%	1.00	7%	1.00	9%
51-100 Employee Group	992,000	29%	1.00	2%	1.00	4%	1.00	7%	1.00	9%
New Merged Market	3,454,000	100%								

Source: Gorman Actuarial estimates

Conclusion

The introduction of new products and significant subsidies for individuals alone could dramatically improve the nature and risk profile of the individual market in New York, resulting in lower premiums generally, even without a merger of the Small Group market. ACA requirements that participating exchange plans offer at least gold and silver actuarial value products, with the possibility of bronze and catastrophic products, will mean premiums for comprehensive products that are significantly lower than those that are available today. While these products will have higher cost-sharing, pooling requirements and state regulations regarding how health plans price products should result in lower premiums for individuals, even for those purchasing products with lower cost-sharing.

Merging the individual and Small Group markets would likely result in lower premiums for individuals, and higher individual enrollment as a result. It is likely that more products would be available to individuals, since health plans would be required to make all products available to Direct Pay and Small Group customers, though ACA provisions will result in new products being offered to individuals. A merger would also reduce the cost of premium and cost-sharing subsidies for the federal government. Premiums would rise somewhat for Small Groups as a result of a merger, however, and could result in small businesses dropping coverage for their workers, increasing cost-sharing, or reducing benefits.

The overall premium impact of a merger on individuals and Small Groups is difficult to determine without actual enrollment numbers and claims data, and it would vary from plan to plan and within certain products. As noted earlier, Small Group customers at health plans with larger enrollment in the Direct Pay market — Empire BlueCross BlueShield, Excellus BlueCross BlueShield, and Oxford Health Plans — are likely to experience larger impacts than other health plans. It is also possible that, as is common

in uncharted waters, health plans facing a new merged market will price products conservatively, risking the possibility of owing refunds under new minimum loss ratio requirements rather than significantly underpricing in what could be a volatile market.

Another option for state policymakers and the newly minted Exchange would focus on making the new market before merging it, and then deciding whether to undertake a merger of market segments on the basis of actual claims and enrollment data. A post-implementation merger would also provide greater clarity on ensuing market dynamics, such as the popularity of the employee-choice distribution method, and employer group decisions to maintain coverage or to drop coverage and contribute through employer responsibility provisions. Should the employee-choice option prove appealing to Small Group employers, and the "pay" option be deemed preferable to the "play" option for employer groups subject to the penalties, the case for maintaining the rating distinction between Small Groups and individuals would become more difficult to justify; it would represent a kind of organic market merger in response to the market dynamic created by the ACA. Greater clarity on outstanding policy issues would also inform a decision on a market merger. Some of these issues — such as the Basic Health Program option — are apparent, but others are less so. The ability of Prepaid Health Services Plans to offer coverage in a merged market, when they currently provide only very limited group market coverage, is just one example of the many considerations that affect a decision to merge markets.

Appendix 1: Data and Methodology

Current Market

We derived our estimates of current enrollment in the Direct Pay and Small Group markets from a variety of sources, including recent Fund publications;[41] the New York State Insurance Department's Health Insurance Data Exhibit (HIDE) for Individual, Non-Medicare Supplement Coverage, and Small Group Non-Medicare Supplement Coverage, first quarter, 2009;[42] the Supplemental Health Care Exhibit — Part 1, filed with the National Association of Insurance Commissioners for calendar year 2010, as an exhibit to their annual statements, by 25 licensed insurers and HMOs operating in New York, representing over $39.3 billion in premiums in total;[43] and 2009 Total Annualized Premium, and 2009 Pool Contributions and Disbursements, Fifth Amendment to Regulation 146.[44] The HIDE data from the Insurance Department was the primary source, as it featured more consistent reporting and was organized in a way that allowed for better estimates of the market share of various products in a single year.

Estimates on the size of the 51-100 employee group market were based on earlier research by the Fund[45] and other sources,[46] and federal labor surveys.[47] We averaged several of these figures to produce an estimate on the employees in this market segment, adjusted it based on various estimates of offer and take-up rates for employer groups,[48] and multiplied it by 2.1, the average contract size. These adjustments produced an estimate of 992,000 employees and dependents.

For the morbidity of the current market segments, we relied on *Merging the Markets*,[49] and the Supplemental Health Care Exhibit — Part 1. This latter source, for example, shows per member per month claims in the individual market of $507, compared to $330 in the Small Group market, although the costs of these claims reflect benefit differences as well. In *Merging the Markets*,

41 Newell P and A Baumgarten. April 2011. *The Big Picture III: Public and Private Health Insurance Markets in New York.* New York: United Hospital Fund.

42 Personal communication, New York State Department of Insurance, March 30, 2011.

43 Freedom of Information Law request, New York State Insurance Department, May 3, 2011.

44 Freedom of Information Law request, New York State Insurance Department, April 15, 2011.

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

46 Blumberg L and AB Garrett. July 2009. *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options.* Prepared for the New York State Department of Health and the New York State Department of Insurance. Washington, D.C.: Urban Institute.

47 Private Industry by Supersector and Size of Establishment: Establishments and Employment, First Quarter 2008, by State. Bureau of Labor Statistics, U.S. Department of Labor.

48 Employer Health Benefits: 2010 Annual Survey. Kaiser Family Foundation and Health Research & Educational Trust, Menlo Park, CA and Chicago, IL; and Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance Component, 2009, firm size and state series.

49 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.

Direct Pay morbidity was estimated to be 2.0 times that of the Small Group Market. However, that analysis excluded the healthier Healthy NY population. This earlier analysis also showed that the morbidity of the entire Healthy NY population was 10 percent lower than that of the Small Group market. However, this analysis included Healthy NY, Small Group, individuals, and sole proprietor enrollees; Small Group Healthy NY subscribers have a lower morbidity than individuals or sole proprietors. Based on our earlier findings, we believe the morbidity difference between the Direct Pay population (including Healthy NY individual and sole proprietor) and Small Group will be less than 2.0, and in this analysis we used a range of 1.5 to 2.0.

Although merging markets requires combining both claims experience and administrative expenses from market segments, administrative costs were not included in this modeling exercise, since they have a much smaller impact on premium change than claims costs.

New Membership

Estimates of new membership were derived from the May 2011 Urban Institute analysis of 2009 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). These estimates reflect an adjustment for the underreporting of Medicaid/CHIP and the overreporting of non-group coverage on the ACS.[50] The Urban analysis estimates that there are 505,000 uninsured citizens between the ages of 19 and 64 with incomes between 139 and 400 percent FPL; 157,000 uninsured citizens between the ages of 19 and 64 with incomes greater than 400 percent FPL; 300,000 uninsured noncitizens between 139 and 400 percent FPL; and 61,000 uninsured noncitizens between the ages of 19 and 64 with incomes greater than 400 percent FPL.

We did not include children in our estimates for a number of reasons, including the relatively small number of uninsured children in New York State who are ineligible for public programs, and the possibility that some of these children might become covered under the children-only coverage offered through the Exchange. For the 19–64 age group with incomes between 139 and 400 percent FPL, we considered the fact that some of these individuals may not be eligible for a subsidy and may not purchase individual coverage because of calculations for Modified Adjusted Gross Income, current eligibility for an employer-sponsored plan, a new coverage offer from an employer, coverage under a spouse's plan, an employer's decision to offer dependent coverage or, for uninsured employees of larger groups, automatic assignment into an employer-sponsored plan. There is also the possibility that employer groups subject to employer-responsibility provisions might pay the penalty and cease providing coverage. For uninsured citizens in the 19–64 age group with incomes above 400 percent FPL, we considered the fact that coverage might not be affordable, and that some individuals would pay a penalty rather than purchase coverage.

Estimates for noncitizens, and the implications of the ACA's treatment of noncitizens, are extremely complex.[51] In evaluating this population, we considered recent Fund research,[52] which estimated that roughly

50 For more information, see: Kenney GM, V Lynch, A Cook, and S Phong. 2010. Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program? *Health Affairs* 29(10):1920-29; and Lynch V. 2011. *Improving the American Community Survey for Studying Health Insurance Reform.* Presented at the Conference on Health Survey Research Methods, Atlanta, April 9, 2011.

51 Wassem RE. 2009. *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation.* Congressional Research Service. Washington, D.C.

52 Holahan D and A Cook. 2009. *Characteristics and Health Insurance Coverage of New York's Noncitizens.* New York: United Hospital Fund.

two-thirds of noncitizens in New York are documented. These individuals would be able to purchase through the Exchange, with or without subsidies, and would possibly be subject to individual responsibility provisions.[53]

Noncitizens who are not lawfully present aliens are not subject to penalties, are permitted to purchase coverage only in the non-Exchange market, and may find new products available in this market, though with similar affordability issues to those facing non-subsidy-eligible citizens.

In developing estimates for new membership, we also reviewed literature related to the impact of the ACA on states, New York in particular.[54] These inquiries used different methodologies, assumptions, and analyses, some with the aid of microsimulation models, and provided a variety of estimates on new enrollment. These estimates were very helpful in creating a range and context for our estimates.

In addition, we tried to put our enrollment estimates for New York's ACA market in a broader context. The Congressional Budget Office,[55] for example, estimates national exchange enrollment of 8 million in 2014. Were New York to enroll over a million new members, that enrollment level would constitute a 12.5 percent share of the enrollment projected nationally, despite the fact that New York's uninsured, including noncitizens and uninsured eligible for public programs, represent just over 5 percent of the nation's total. Were New York to enroll over 400,000 new members in 2014, it would match the total enrolled in the Disaster Relief Medicaid program in the five months following the September 11 attacks,[56] a program with markedly simpler enrollment procedures. By the same token, enrollment in Family Health Plus began in October 2001 and didn't reach 450,000 until October 2004.[57]

For the purposes of these estimates, we made several assumptions. While the Basic Health Program will be the subject of a lively and complex discussion in New York, we did not assume that it would be adopted and operational by January 2014. We also assumed that sole proprietors and individuals currently enrolled in the Healthy NY program would be migrated to Exchange products, and new Healthy NY enrollment for individuals, sole proprietors, and Small Groups would be suspended; and that a significant share of individual and Small Group coverage in effect on March 23, 2010, would be pooled with new coverage. We did not estimate the impact of individual responsibility provisions on employer-sponsored coverage, or the impact of employer-responsibility provisions on new individual coverage. The tables below show further assumptions on take-up of coverage of four segments of the uninsured population between the ages of 19 and 64, and with incomes of 139 percent FPL and higher, under our low-end and high-end estimates.

53 Siskin A. March 2011. *Treatment of Noncitizens under the Patient Protection and Affordable Care Act.* Congressional Research Service. Washington, D.C.

54 Holahan J and L Blumberg. January 2010. *How Would States Be Affected by Health Reform?* Princeton, NJ: Urban Institute for the Robert Wood Johnson Foundation; Holahan J and S Dorn. June 2010. *What Is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States?* Princeton, NJ: Urban Institute for the Robert Wood Johnson Foundation; Boozang P, M Dutton, A Lam and D Bachrach. August 2010. *Implementing Federal Health Care Reform: A Roadmap for New York State*. New York: Manatt Health Solutions.

55 Correspondence from Douglas W. Elmendorft, Director, Congressional Budget Office, to Speaker Nancy Pelosi, U.S. House of Representatives, March 20, 2010.

56 Haslanger K. 2003. Radical Simplification: Disaster Relief Medicaid in New York. *Health Affairs* 22(1):252-258.

57 United Hospital Fund analysis of New York State Health Department enrollment data.

Table 8: **New Membership — Low-End Estimate**

Uninsured Category	Number	Assumption	Take-Up
Citizens, 139-400% FPL	505,000	0.50 take up	252,500
Citizens, >400% FPL	157,000	0.50 take up	78,500
Noncitizens, 139-400% FPL	300,000	0.63 are documented, and 0.50 of this group take up	94,500
Noncitizens, >400% FPL	61,000	0.63 are documented, and 0.333 of this group take up	12,682
Total	1,023,000		438,182

Source: Population data from Urban Institute, May 2011. Based on the 2009 American Community Survey data from the Integrated Public Use Microdata Series (IPUMS); assumptions by United Hospital Fund

Table 9: **New Membership — High-End Estimate**

Uninsured Category	Number	Assumption	Take-Up
Citizens, 139-400% FPL	505,000	0.80 take up	404,000
Citizens, >400% FPL	157,000	0.80 take up	125,600
Noncitizens, 139-400% FPL	300,000	0.63 are documented, and 0.75 of this group take up	141,750
Noncitizens, >400% FPL	61,000	0.63 are documented, and 0.50 of this group take up	19,215
Total	1,023,000		690,565

Source: Population data from Urban Institute, May 2011. Based on the 2009 American Community Survey data from the Integrated Public Use Microdata Series (IPUMS); assumptions by United Hospital Fund

New Membership Morbidity

We reviewed a range of literature on the health status of the uninsured.[58] We also used the May 2011 Urban Institute analysis of the American Community Survey to explore the relative age of the uninsured in New York compared to that of the insured market, and we reviewed census data to compare the self-reported health status of the uninsured to that of insured individuals and individuals insured through the employer market. Table 10 shows that uninsured who will make up new membership under the ACA are generally younger than individuals currently insured under employer-sponsored or Direct Pay coverage, and thus less likely to incur medical

58 Henry J. Kaiser Family Foundation. March 2011. *A Profile of Health Insurance Exchange Enrollees. Focus on Health Reform.* Menlo Park, CA: Kaiser Family Foundation; Pourat N, C Kinane and G Kominski. May 2011. *Who Can Participate in the California Health Benefit Exchange? A Profile of Subsidy-Eligible Uninsured and Individually Insured.* Los Angeles: UCLA Center for Health Policy Research; Bhandari S. February 2006. *Health Status, Health Insurance, and Health Services Utilization: 2001. Current Population Reports, Household Economic Studies.* Washington, DC: US Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration; Machlin MS and D Woodwell. April 2009. *Healthcare Expenses for Chronic Conditions among Non-elderly Adults: Variations by Insurance Coverage, 2005-06 (Average Annual Estimates).* Statistical Brief #243. Agency for Healthcare Research and Quality.

claims. Table 11 summarizes self-reported health status by market segment, illustrating the relationship of the health status of the uninsured to that of individuals in the employer-sponsored and individual markets.

All these studies suggest that the relative morbidity of this new Exchange population in New York may look more like Small Group on one end, or perhaps higher, but not as high as the existing Direct Pay market. In addition to morbidity differences, there may also be some pent-up demand for this newly insured population.

We estimated that the relative morbidity of the uninsured population ranges from 1.00 to 1.25. That is, with benefits being equal, the average medical expenses for the newly insured would be equal to those enrolled in the Small Group market or up to 25 percent higher.

Table 10: **Age of Uninsured and Insured Populations**

		Insured	
Age Group	**Uninsured**	**Employer-Sponsored**	**Direct Purchase**
0-18	10.1%	25.2%	20.6%
19-24	18.5%	7.8%	15.7%
25-34	28.0%	14.5%	15.2%
35-54	34.8%	37.1%	29.9%
55-64	8.6%	15.3%	18.6%

Source: Urban Institute, May 2011. Based on the 2009 American Community Survey data from the Integrated Public Use Microdata Series (IPUMS)

Table 11: **Self-Reported Health Status of Uninsured and Insured Populations**

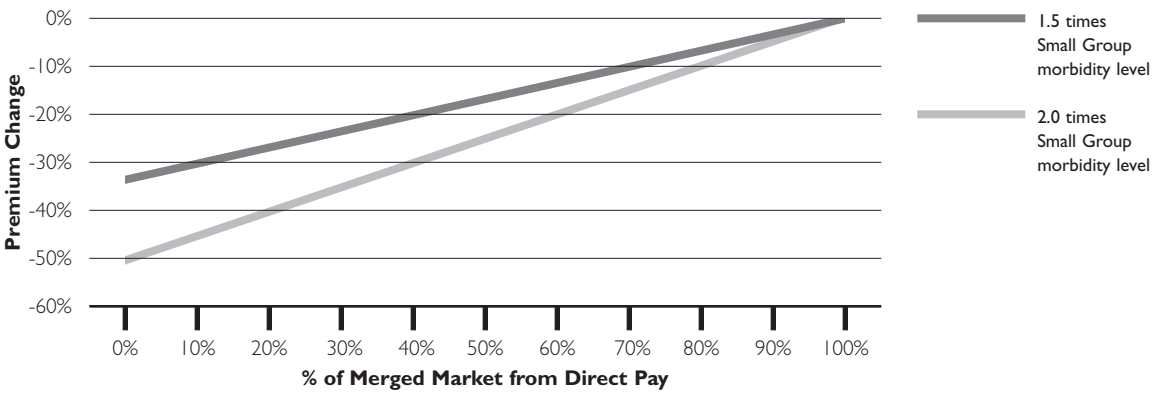
		Insured	
Health Status	**Uninsured**	**Employer-Sponsored**	**Direct Purchase**
Excellent	32.6%	39.0%	31.3%
Very Good	35.3%	35.1%	28.0%
Good	24.3%	20.6%	29.2%
Fair	6.5%	4.1%	8.9%
Poor	1.3%	1.2%	2.7%

Source: Current Population Survey (CPS) Table Creator for the Annual Social and Economic supplement, 2010. U.S. Census Bureau

Appendix 2: Morbidity and Market Share in Market Mergers

Two sets of estimates were the foundation of this analysis: enrollment and morbidity for current market segments, and projected enrollment and morbidity for new membership in the market. With what we believe is a reasonable assumption of the morbidity of the various market segments, it became apparent in our analysis that there is a limit on the amount of cross-subsidization that could take place between these market segments. The figure below shows premium change on the Y-axis, and the Direct Pay market share as a percent of the merged market on the X-axis. Assigning a 1.0 morbidity value to Small Group coverage, we graphed two options for Direct Pay market morbidity, 1.5 (50 percent higher than Small Group) and 2.0 (100 percent higher than Small Group). As shown, as Direct Pay market share increased, the impact of cross-subsidies decreased and premiums increased. Cross-subsidies, shown as a decrease in premium, increased as morbidity differences increased, and greater premium change occurred at a morbidity of 2.0. However, the premium changes or cross-subsidies were bound by the morbidity difference, no matter how small the Direct Pay market share was of the merged market. The maximum premium changes — 50 percent for the higher morbidity estimate and 33 percent for the lower morbidity estimate — occurred when the Direct Pay market made up just one percent of the merged market. Premium changes decreased as Direct Pay market share increased, leveling off at 0 percent when the Direct Pay market represented 100 percent of the merged market. Premiums can only decrease to the level of premiums for the subsidizing population. If morbidity differences for Small Groups and individuals result in premiums of $100 and $150, respectively, the maximum benefit to individuals in terms of a premium change is $100, a 33 percent decrease in the Direct Pay premium.

Figure 1: **Premium Change in Market Merger: Interaction of Morbidity and Direct Pay Market Share**



Source: Gorman Actuarial, LLC

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