BENEFITS OF NONPROFIT HEALTH PLANS TO A REGION

COMPARING ECONOMIC VALUE AND COMMITMENT TO THE UNDERSERVED IN NEW YORK STATE.

PREPARED BY:
TREO SOLUTIONS
FOR THE
ALLIANCE FOR ADVANCING
NONPROFIT HEALTH CARE.

Executive Summary

Following on the heels of the first national study demonstrating differences in the community benefits provided by not-for-profit and for-profit HMOs[1], this study of the New York State market shows significant differences in premiums, administrative overhead and commitment to safety net coverage between non-profit and for-profit health plans. This study shows that for-profit health plans do act differently than not-for-profit plans in terms of performance, efficiency, and contribution to safety net programs. Moreover, it suggests that not-for-profit health insurers operating in a predominantly for-profit market act in many ways like for-profits.

The New York State insurance market provides an ideal study environment because one can compare a large number of policyholders and plans in both business models (for-profit and not-for-profit) that share an identical legislative and regulatory environment. New York has large populations being provided coverage under both models and no allowances had to be made for state-to-state political and/or legal differences. Specifically, this study shows that:

[1] Schlesinger, M., S. Mitchell and B. Gray. Summer 2003. Measuring Community Benefits Provided by Nonprofit and For-Profit HMOs. Inquiry 40: 114-132.

Executive Summary (Cont.)

• The downstate insurance market is predominantly for-profit, while the upstate market is almost entirely not-for-profit. The recent conversion of Empire Blue Cross Blue Shield to a for-profit model moves the downstate market further into the for-profit column, while the upstate region remains not-for-profit.

• Insurers in the upstate not-for-profit market are more administratively efficient than insurers in the downstate region. Compared to the downstate region, insurers in upstate New York spent 1.5% less of their operating revenues on administrative expenses. The additional 1.5% of spending on administrative expenses downstate totals $137,000,000.

• Upstate insurers spend significantly more of the revenues received on payments for medical care. Downstate insurers spent 80.4% of operating revenues on medical care. Upstate insurers spent 87.7% of operating revenue on medical care. If health care spending patterns downstate were similar to upstate, the additional 7.4% allocated to medical care would total $678,000,000.

• A lower level of investment in medical care in the downstate region translated into higher underwriting gains, which totaled 8.1% of operating revenue. Plans in the upstate region reported underwriting gains of only 2.3%.

• Not-for-profit insurers offer more cost effective (i.e., lower) premium options for consumers. In 2002, the upstate market had the lowest operating revenues (premiums) statewide, averaging $184 per member per month (pmpm) in, and the not-for-profit plans downstate averaged $203 pmpm. Premiums in the for-profit segment of the downstate market averaged $221 pmpm in 2002.[2]

• The not-for-profit upstate market has proved its viability, while maintaining commitments to NYS safety net and Medicare programs. The not-for-profit upstate market experienced a $12 million loss in NYS safety net programs in 2002, but generated $131 million in underwriting gains for all product lines combined. Furthermore, upstate revenue gains in 2002 exceeded 2001 results by $45 million.

• Not-for-profit HMOs, both upstate and downstate, participate in state-sponsored safety net programs to a far greater degree than the downstate for-profit managed care organizations. Within the plan group selected for this study, the not-for-profit plans supported 88% of the enrollment in New York State sponsored programs, compared with for-profit plans, support of only 12% of safety net membership.

• Not-for-profit plans have also demonstrated a higher level of dedication to the Medicare Plus Choice product line than for-profit insurers downstate. In 2002, not-for-profit plans enrolled 73% of this population of 385,000 elderly statewide. Despite the favorable financial returns in the product line, for-profit insurers downstate enrolled only 105,000 Medicare Risk members in 2002, or 27% of the statewide total.

The emergence in New York of healthcare insurance markets that are predominantly for-profit raises significant public policy issues, especially with reference to community benefits and services. Should the upstate health insurance environment change with the entrance of for-profit plans, or conversion of existing plans to for-profit status, the upstate market is likely to look very similar to the downstate in that:

- There will be diminished access to care for the at-risk population;
- Premium costs will be higher;
- Administrative costs will be higher.

The healthcare insurance market upstate would become less attentive to the provision of public goods as insurers strive to maximize their economic advantages.

[2] It was beyond the scope of this study to specifically determine what factors explain the differences in premium levels, such as the costs of do o st eihf

B. Overview of the NYS Insurance Markets

Finding: The downstate insurance market is predominantly for-profit, while the upstate market is almost entirely not-for-profit. The recent conversion of Empire Blue Cross Blue Shield to a for-profit model moves the downstate market further into the for-profit column, while the upstate region remains largely not-for-profit.

As of 2002, the upstate market was composed of 6 not-for-profit insurers, and the downstate region included 4 not-for-profit and 6 for-profit managed care plans. The upstate market also includes a large number of for-profit third party administrators that manage self-insured benefits for employers, but data for these entities are not included in this study. Total membership in the 16 surveyed plans was 5.5 million, with 56% of the members enrolled in 10 downstate plans and 44% of the membership enrolled with 6 upstate insurers, as profiled in Table 1 below. The for-profit plans downstate enrolled 1.98 million members, or 64% of the region, and the recent conversion of Empire Blue Cross Blue Shield's 200,000 members will increase the for-profit population in the region to 70% in 2003.

Table 1
New York State Insurance Market – Managed Care Plans
Summary of Upstate and Downstate Enrollment

Source: Apollo TM Managed Care

Table 1 provides the total annual average enrollment for the selected 16 managed care plans by region and profit status. Note that the number of plans is based on the 2002 membership period only. Additional information regarding health plan selection criteria for 2001 and 2002 is included in the Appendix to this report.

Managed care enrollment statewide decreased by 9.9%, or nearly 602,000 members, between 2001 and 2002. Downstate managed care enrollment dropped a total of 13.5% or 482,000 members, from 2001 to 2002; upstate managed care membership decreased a total of 4.8%, or 120,000 members, over the two-year period. Downstate for-profit plans accounted for most of the enrollment shift in the region with a decrease of 373,000 managed care members. The declining trend in managed care enrollment statewide may be related to consumer migration into non-managed insurance options, such as indemnity and preferred provider organization (PPO) programs.

C. Impact of Profit Status on Consumer Premiums

Finding: Not-for-profit insurers offer more cost effective premium options for consumers.

The upstate market had the lowest operating revenues (premiums) for the 2001-02 period, averaging $184 pmpm in 2002, with an increase over 2001 results by 12.1% (see Table 2). For-profit plan revenues were 8.8% higher in 2002 than not-for-profit plans in the downstate market, with for-profit insurers averaging $221 pmpm and not-for-profits averaging $203 pmpm. Downstate market premiums for all carriers averaged $215 pmpm in 2002, an increase of 12.9% over 2001 average premiums.

Downstate not-for-profit insurer premiums increased 10% in 2002, while the for-profits trended 14.2%. The for-profit insurers' enrollment majority and higher premium levels drove the results in the overall market, as seen in Table 2.

Table 2
NYS Commercial Managed Care Products Revenue Trends by Market, 2001-2002

Source: Apollo Managed Care TM

Table 2 provides a comparison of operating revenues in the various market regions. Operating revenue includes income primarily from premiums, but also includes changes in reserves, reinsurance, fee for service, and aggregate write-ins. Investment income is not included in the per-member-per-mon v maris

D. Profit Status and Commitment to Safety Net Programs

Finding: Not-for-profit HMOs, both upstate and downstate, participate in state-sponsored safety net programs to a far greater degree than downstate for-profit managed care organizations.

Table 3 profiles distributions of enrollment in safety net programs (i.e., Medicaid and other state–sponsored benefits) by profit status. The data reveal that for-profit status has a significant influence on plan behavior in this area, with not-for-profit insurers making much greater investments in safety net product lines. In 2002, contributions to safety net programs represented 3% of enrollment in for-profit plans, compared with 12% of membership in not-for-profit organizations. In fact, of the 474,000 individuals enrolled in NYS safety net programs, 88% were members of not-for-profit health plans, compared with for-profit plans' enrollment of only 12% of the safety net population.

Table 3
Distribution of Enrollment by Product in NYS Markets, 2002

Source: Apollo Managed Care TM
The types of products summarized in Table 3 include commercial (HMO, point of service and direct pay), Medicare Plus Choice, Medicaid and other government programs (Child Health Plus, Family Health Plus and Healthy New York). Although the Healthy New York program is a mandated offering for all insurers, the program is higher risk than traditional programs and the profit status of the insurer may impact incentives to drive membership into it.

Finding: Not-for-profit plans have also demonstrated a higher level of dedication to the Medicare Plus Choice product line than for-profit insurers downstate.

As shown in Table 3, not-for-profit insurers enrolled 8% of their insured population in the Medicare Plus Choice line of business. The for-profit segment of the NYS market enrolled 5% of its members in the Medicare Plus Choice product line. During 2001 and 2002, Medicare Plus Choice was an income-generating product line for insurers statewide, despite the high-risk nature of the senior population. Revenue gains in this product line were higher downstate than upstate due to more favorable federal payment rates. In 2002, not-for-profit plans supported 280,000 seniors, or 73% of the statewide total of 385,000 enrolled. Despite the favorable returns in the product, for-profit insurers enrolled only 27% of the statewide total, or 105,000 seniors.

Market observers have questioned the willingness of for-profit insurers to participate in programs that serve disadvantaged populations such as children, the elderly, low-income persons and the uninsured. For-profit insurers need to satisfy the demands of equity holders, who have a legal claim on the income generated from operations. Not-for-profit insurers have no legal claimants on residuals and can use them to support community needs. In considering these factors and the NYS market data, it stands to reason that as a market becomes dominated by for-profit carriers, investments in safety net programs may decline substantially.[4]

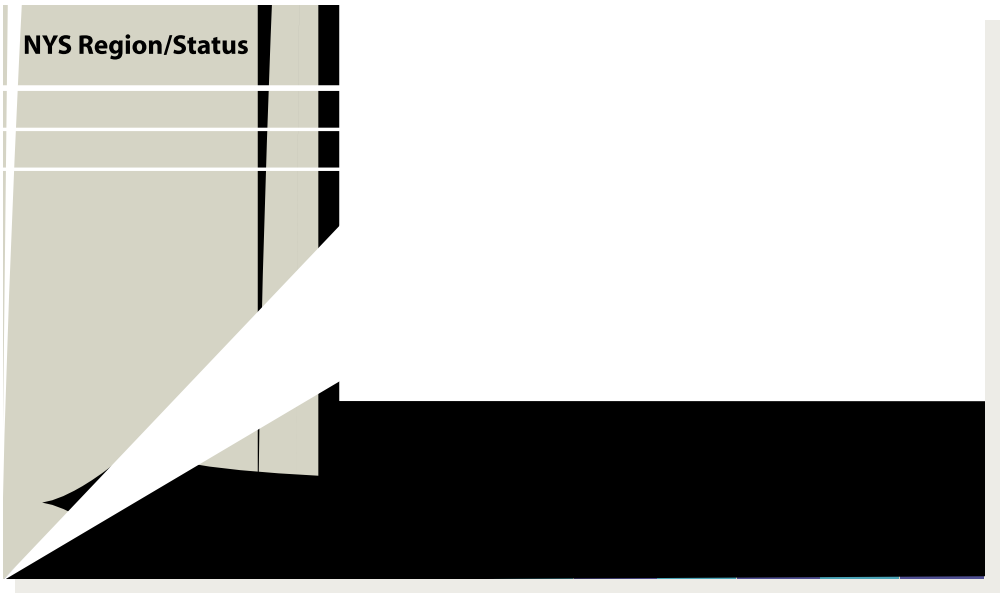
E. Market Financial Performance and Uses of Consumer Dollars

The willingness of not-for-profit insurers to contribute to safety net and Medicare programs is well understood in view of the enrollment data.

Finding: The not-for-profit upstate market has proved its viability while maintaining commitments to NYS safety net and Medicare programs.

Table 4 provides an overview of managed care enrollment and underwriting gains by product line for 2001-02 in the upstate and downstate markets. The not-for-profit upstate market experienced a $12 million loss in NYS safety net programs in 2002, but generated $131 million in underwriting gains for all product lines combined. Furthermore, upstate underwriting gains in 2002 exceeded 2001 results by $45 million.

Table 4
Regional Underwriting Income Results, 2001-02



Source: Apollo Managed Care TM

In Table 4, underwriting income is defined as total operating revenue less medical and administrative expenses, and results provided do not include the impact of investment income or taxes. NYS Safety Net Programs include Medicaid, Child Health Plus, Family Health Plus and Healthy New York.

Finding: As markets become increasingly for-profit, the revenue focus is placed more on commercial product development and profitability and less on community programs. Net incomes (underwriting gains) generated in the for-profit downstate market are primarily focused in commercial products.

The data reveal that managed care plans in the downstate market reported favorable returns in 2002 for all product lines, with aggregate gains at $750 million, a $302 million improvement over 2001 results. In 2002, $545 million, or 73% of the downstate underwriting gains, was generated in commercial lines of business, compared with 62% of gains ($81 million) generated in commercial lines upstate. The percentage of revenues generated by commercial lines in 2002 was similar to 2001 results for upstate and downstate markets.

While the upstate market overall became more viable in 2002, underwriting gains were tempered by investments made in NYS safety net products. The significant revenues generated downstate resulted from the majority of the plans in the region having a for-profit status with lower levels of participation in safety net and Medicare Plus Choice programs.

Finding: An insurance market's transition to an increasingly for-profit environment also impacts the distribution of healthcare dollars in the local marketplace.

Table 5 outlines the distributions of medical, administrative and underwriting gain dollars in New York's downstate and upstate insurance market sectors for 2002. Allocations of dollars in the revenue and expense items varied substantially between the two markets:

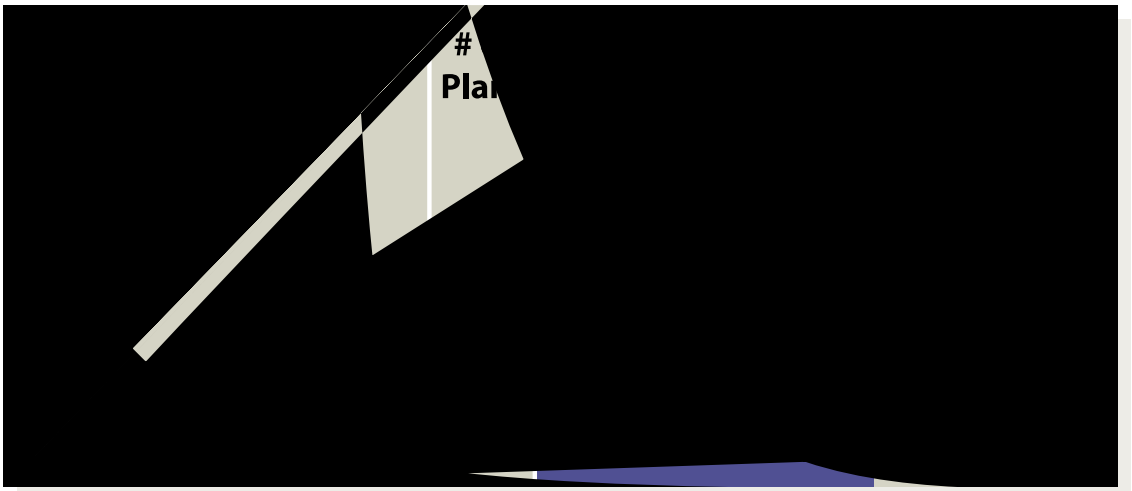
Table 5
Regional Allocation of NYS Managed Care Dollars, 2002

Source: Apollo Managed Care TM

• **Compared with their downstate neighbors, insurers in upstate New York spent significantly more of the available consumer dollars on medical care. In downstate dollars, this shift in spending totals $678 million.**

The plans surveyed in the upstate market reported operating revenues totaling $5.8 billion in 2002, 87.7% of which was allocate 78atllot7lo8aftca8a s

Table 6
New York State Insurance Market – Non-HMO Product Lines
Summary of Upstate and Downstate Enrollment



Source: NYS Insurance Department - Health, Medical, Dental and Indemnity filings, 2002; National Association of Insurance Commissioners - Life, Accident and Health filings, 2002. Some of the plans provide dental coverage and 'out of network' benefits for managed point-of service plans – therefore some enrollment may duplicate that presented in Table 1. Additional detail is available in the Appendix.

F. Survey of Other Lines of Business Offered by NYS Major Insurers

The significant findings in this study were derived from data provided to New York State regulators by commercial managed care plans in New York State, the most comprehensive source of health insurance enrollment and financial data available. In order to address the other 'non-HMO' lines of business offered by these same insurers in New York, such as indemnity, PPO and other types of products, additional data were collected for New York State health plans from the New York State Insurance Dept (NYSID) and the National Assoc. of Insurance Commissioners (NAIC). Data for the non-managed product lines are summarized in Table 6. Enrollment and financial findings related to these plans are presented below. Note that the data provided in this section do not include self-insured lines of business.

A total of 10 health insurers provided 2002 enrollment and financial data for New York State operations to the NYSID and NAIC. In 2002, the upstate market had 5 not-for-profit plans, and the downstate market had 2 not-for-profit and 3 for-profit plans, with 62% of the enrollment in the for-profit model. Total membership in the surveyed plans was 6.6 million, with 67% of the members enrolled in downstate plans and 33% enrolled upstate. Not-for-profit enrollment totaled 3.8 million statewide, while for-profit enrollment totaled 2.8 million.

The regional allocation of healthcare dollars for the non-managed plans is presented in Table 7. Allocations of dollars for revenue, expenses and underwriting results varied between the upstate and downstate markets.

Finding: Similar to findings in the managed care data, the non-HMO product lines data show that not-for-profit plans spend a higher percentage of dollars on health care and a lower percentage of dollars on administrative expenses.

Non-managed lines of business in both markets reported favorable returns in both markets in 2002, with upstate insurers gaining $139 million and the downstate insurers reporting $62 million. Similar to managed care market results, the upstate market spent a higher percentage of operating revenues on medical care, a variance of 2% compared with the downstate market. Also consistent with managed care findings, administrative spending in the downstate market exceeded the upstate market proportionately by 3.2%.

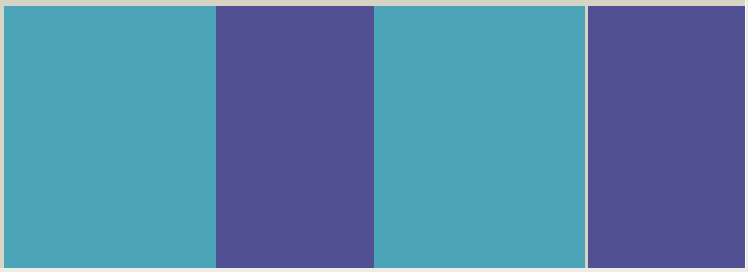
Unlike the managed care findings in Table 5, the underwriting gains on a percentage basis were 1.2% higher in the upstate not-for-profit market as compared with down-state, which enrolls a higher percentage of lives in the for-profit model.

The findings based on non-HMO product lines should be viewed with caution, as the dollar amounts shown in Table 7 reflect a number of diverse products such as indemnity plans, PPO plans, out-of-network components of managed point-of-service plans, Medicare supplemental plans and dental plans.

Similar to managed care market results, the upstate market spent a higher percentage of operating revenues on medical care, a variance of 2%.

Table 7
Regional Allocation of NYS Non-Managed Care Dollars, 2002

Category	Upstate Market	% of Revenue		% of Revenue



Source: NYS Insurance Department - Health, Medical, Dental and Indemnity filings, 2002; National Association of Insurance Commissioners - Life, Accident and Health filings, 2002. Additional detail is available in the Appendix.

G. Conclusion

As conversions by hospitals and health plans have accelerated around the country, public discourse about their impact on access to care and other community benefits has intensified. The conversion of Empire Blue Cross Blue Shield heightened the public debate in New York State about access to care, the uninsured, and the preservation and use of the "charitable asset."

The Empire conversion and the transition of the downstate health insurance market to predominantly for-profit status, have made the need to maintain growth the primary objective of the for-profit entities. "Once you become a for-profit entity and take on public equity capital, especially in a high-growth industry, you cannot decide to reject the 'grow or go' imperative because your investors fully expect earnings growth of 15 percent or better, year after year."[5] **This report demonstrates that for-profit health plans *do act differently* than not-for-profit plans in terms of performance, efficiency and contribution to safety net programs.** Moreover, it suggests that not-for-profit health insurers operating in a predominantly for-profit market act in many ways like for-profits.

In a report published by the Milbank Memorial Fund entitled, *"Nonprofit and For-Profit HMOs: Converging Practices but Different Goals?"* it was noted that as competition and for-profit ownership increases in a marketplace, "the weight accorded to business interests, professional principles, and social concerns changes."[6]

> "Many of the attributes that once made nonprofit prepaid integrated plans distinctive are disappearing as competition compels non-profits to be less attentive to the public good. While granting that the form of ownership does not determine quality, it is nevertheless apparent that the growth of for-profit ownership is driven by market forces with little or nothing to do with social mission, a traditional element of health care delivery. Ever more centralized in larger corporations and ever more profit motivated, the health-care system is embroiled in a frenzy of deal-making that is changing the weight accorded to business interests, professional principles, and social concerns. What will happen to health care in communities as providers and health plans continue striving to maximize their economic advantages, and as regulators respond to the competing pleas of health care producers, purchasers, and consumers?"[7]

This report shows that:

- An insurance market's transition to an increasingly for-profit environment impacts how healthcare dollars are spent in the local marketplace;
- As markets become increasingly for-profit, the revenue focus is placed more on commercial product development and profitability and less on NYS safety net and Medicare programs;
- Not-for-profit plans have demonstrated a higher level of dedication to the Medicare Risk product line than for-profit insurers downstate.

The emergence in New York of healthcare insurance markets that are predominantly for-profit raises significant public policy issues, especially with reference to community benefits and services. As this report outlines, the downstate health insurance market is quite different from the upstate insurance market, and insurers in the two markets act differently. Should the upstate health insurance environment change with the entrance of for-profit plans, or conversion of existing plans to for-profit status, the upstate market is likely to look very similar to the downstate in that:

- **There will be diminished access to care for the at-risk population;**
- **Premium costs will be higher;**
- **Administrative costs will be higher.**

The healthcare insurance market upstate would become less attentive to the provision of public goods as insurers strive to maximize their economic advantages.

[5] Jack Needleman, "*Nonprofit to For-Profit Conversions by Hospitals and Health Plans: A Review*," Pioneer Institute for Public Policy Research.
[6] Harry Nelson, "*Nonprofit and For-Profit HMOs: Converging Practices but Different Goals?*" Milbank Memorial Fund, 1997.
[7] Ibid.

Appendix

Data Resources and Disclaimers

For the purposes of this study, Treo Solutions relied on the following data sources:

- Treo Solutions' proprietary Apollo Managed Care™ database of financial and enrollment data derived from the New York State HMO Data Requirements annual reports.

- Life, Accident and Health (LAH) regulatory filings for New York health plans.

- Health, Medical, Dental and Indemnity (HMDI) regulatory filings for New York health plans.

The HMO Data Requirements reports are the most comprehensive source of public data available on health insurance organizations in New York State, and include data for Article 44 licensed insurers only. The Data Requirements reports do not include data for non-managed insurance programs such as indemnity, preferred provider organizations and self-insurance. Regulatory reporting data for fully insured non-HMO programs are more limited in scope and were accessed from LAH filings (National Association of Insurance Commissioners) and Article 43 HMDI filings (NYS Insurance Department) as available for plans reporting at least a portion of their enrollment in indemnity, point-of-service or PPO product lines. The data periods included in the analysis were calendar years 2001 and 2002. All data were gathered from 'current year' statistics provided in each health plan's statement.

This report contains information compiled from sources that Treo Solutions does not control and this information, unless otherwise indicated in this report, has not been verified. In furnishing this report, Treo Solutions in no way assumes any part of The Alliance For Advancing Non-Profit Health Care's business risk, does not guarantee the accuracy, completeness or timeliness of the information provided and shall not be liable for any loss or injury resulting from contingencies beyond its control or from negligence.

Approach

Treo Solutions compiled data from 28 insurance organizations for the analysis and classified them according to geographic location and profit status. Exhibit A-1, NYS Insurance Organizations - Geography and Profit Status, lists the organizations selected for review.

Downstate plans are defined as having the majority of membership located in Rockland and Westchester counties and south to the New York City boroughs. Upstate plan enrollments include all areas north of Westchester and Rockland counties. Geographic locations were determined from the health plans' reported memberships for 2002. Although Empire Blue Cross Blue Shield converted to a for-profit plan in 2002, the plan was a not-for-profit entity until September of 2002, and is classified as such for the purposes of this report. Empire reported data under two different plan numbers during 2001 and 2002, and is counted as two different entities. Empire Healthchoice HMO, Inc. was formed in 2002 in advance of the for-profit conversion, which took place shortly after the end of the third quarter 2002 data period.

To assure comparability and credibility of the financial and enrollment indicators in the study, only plans with enrollment exceeding 10,000 covered lives and a majority of membership in commercial product lines were selected. For this reason, several organizations were excluded from the analysis due to size criteria or a high concentration of enrollment in public programs such as Medicare and Medicaid. The excluded plans are as follows:

- AmeriChoice of NY, Inc.
- Elderplan, Inc.
- Horizon Healthcare of New York, Inc.
- MagnaHealth of New York
- MDNY Healthcare, Inc.
- MetroPlus Health Plan
- United Healthcare of Upstate NY, Inc.
- Wellcare of New York, Inc.

Exhibit A-1
NYS Insurance Organizations - Geography and Profit Status

Sources: NYS HMO Data Requirements, 2001-02; NYS Insurance Department Health - Medical and Indemnity Plan filings, 2002; National Association of Insurance Commissioners - Life, Accident and Health Plan filings, 2002.

1 Data Used for 2002 only
2 Plan excluded in 2002 due to high percentage of government product enrollment

Additional summary data compiled by market for 2001 and 2002 are provided in Exhibits A-2 through A-7. The data include enrollment, revenue and expense profiles and loss ratio summaries for plans selected for the study.

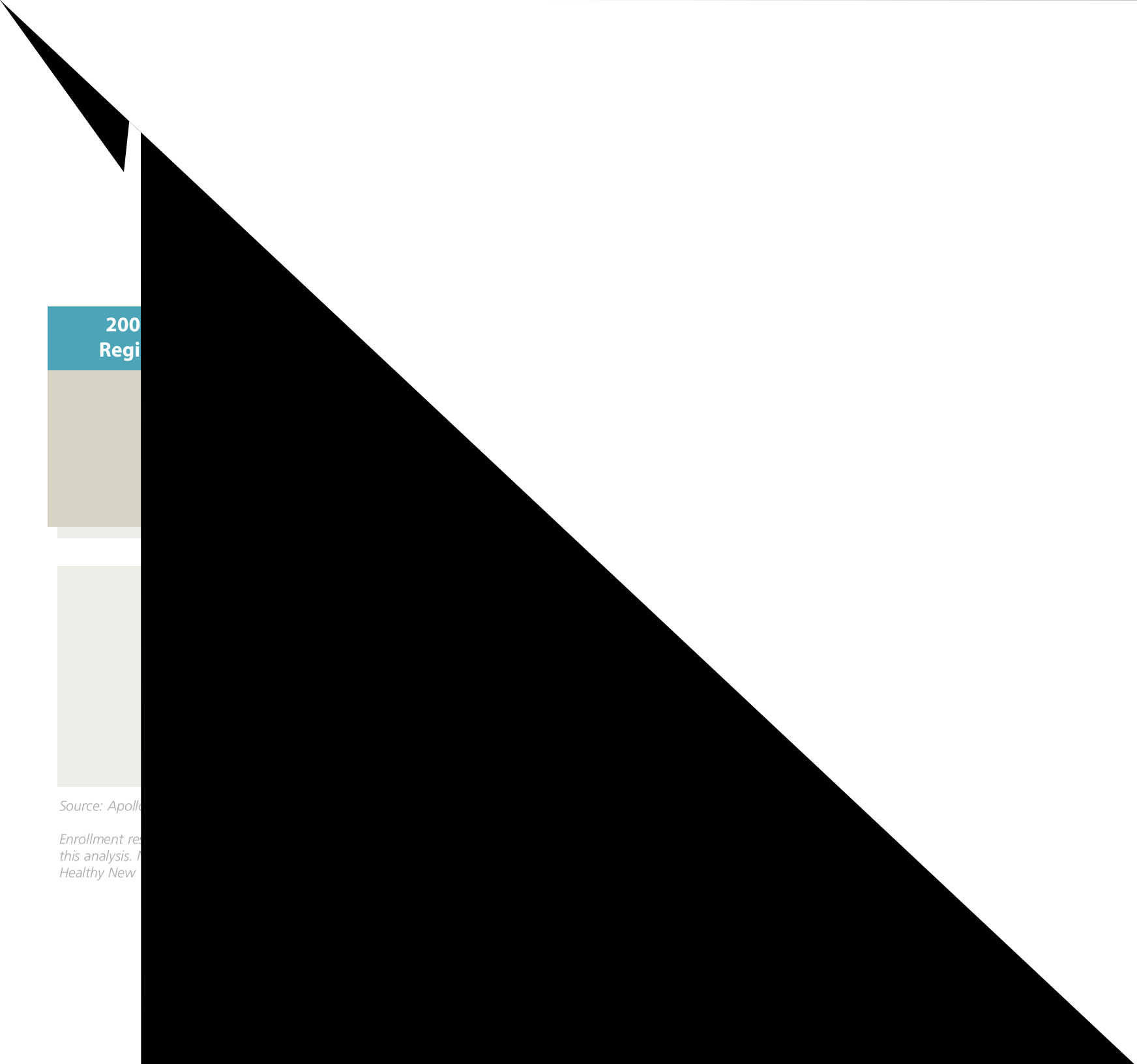


Exhibit A-3
2001 Operating Results Per Member Per Month (PMPM)
By Region and Profit Status
NYS Managed Care Plans

Exhibit A-4
2002 Operating Results Per Member Per Month (PMPM)
By Region and Profit Status
NYS Managed Care Plans

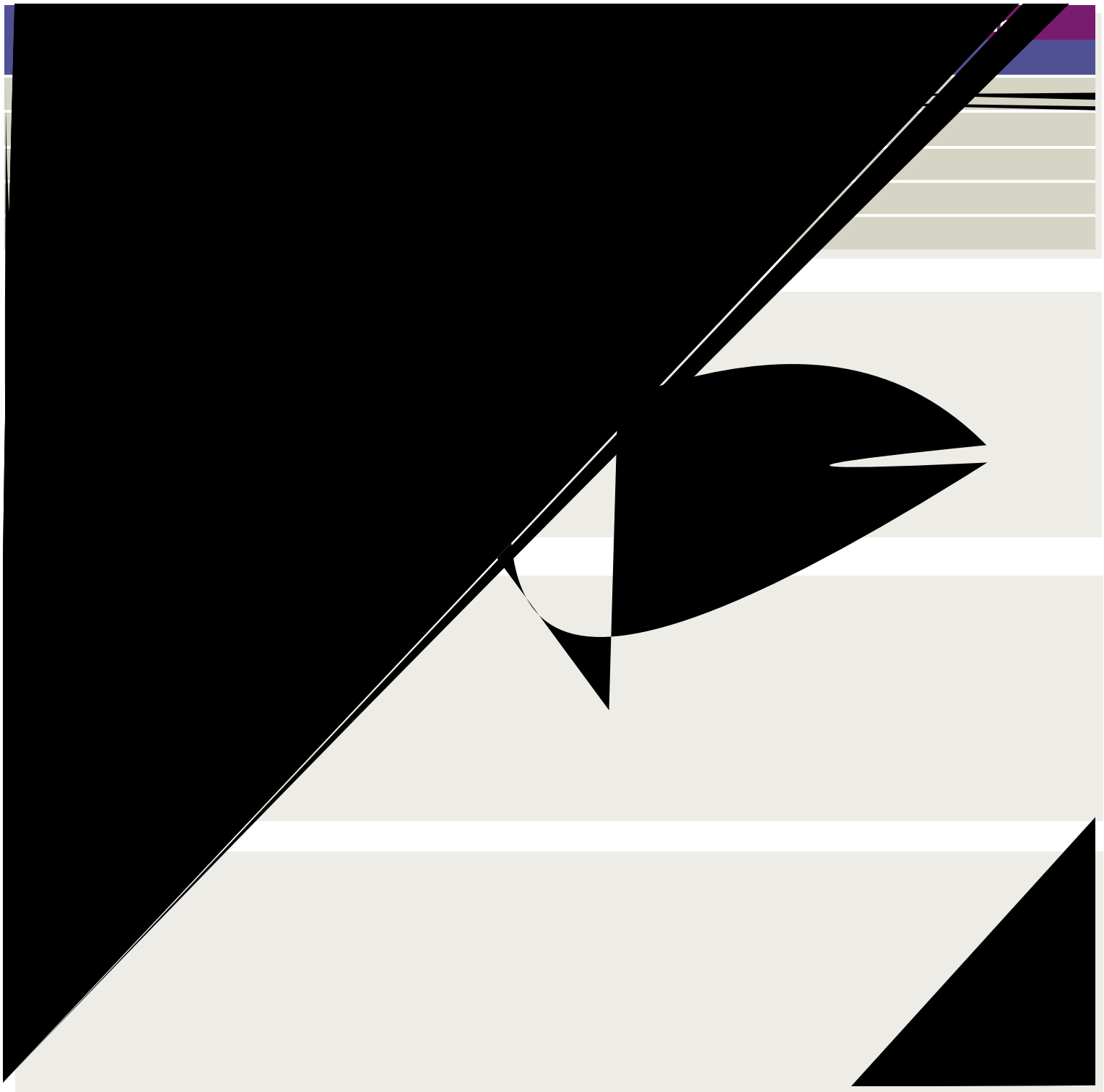
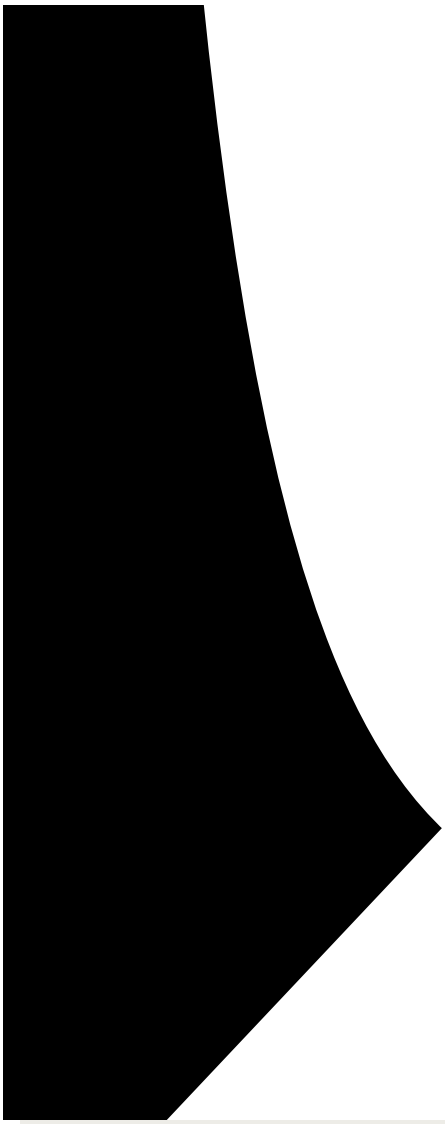
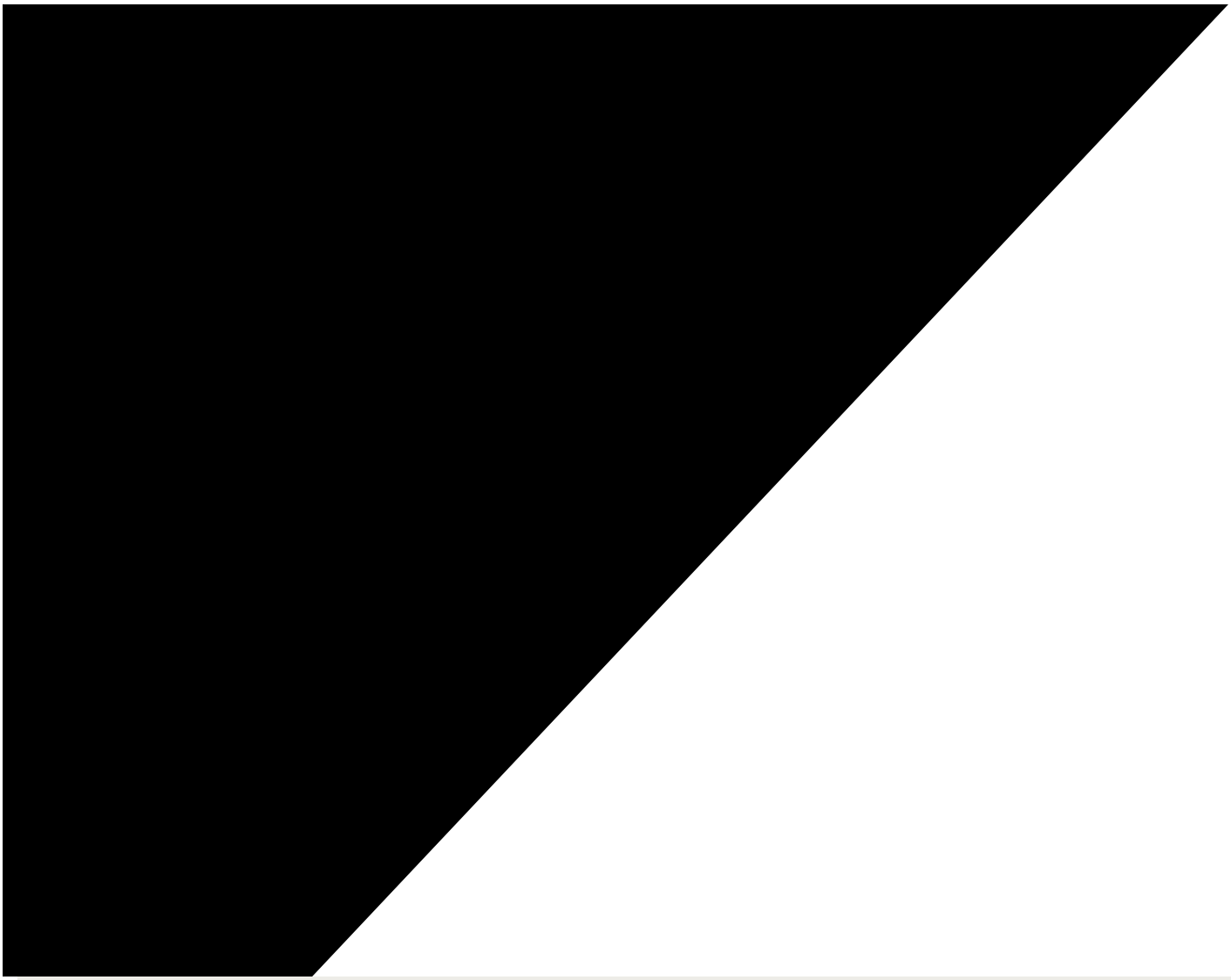


Exhibit A-5
2001 Administrative, Medical and Underwriting Ratios
By Region and Profit Status
NYS Managed Care Plans



Source: Apollo Managed Care TM

Exhibit A-6
2002 Administrative, Medical and Underwriting Ratios
By Region and Profit Status
NYS Managed Care Plans



Source: Apollo Managed Care TM

Exhibit A-7
2002 Administrative, Medical and Underwriting Results
By Region and Profit Status
NYS Managed Care Plans

Source: Apollo Managed Care TM