



UnitedHealth Group

**New York's Direct Pay and Small Group Markets:  
Reform Ideas  
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## **New York's Direct Pay and Small Group Markets: Reform Ideas**

*The following paper provides an overview of the current problems facing the individual/Direct Pay market in New York State and offers solutions to address the problems. The solutions proposed by United Health Group are designed to both address the unique issues of the state and be acceptable to the political leadership of New York. Thus we offer these suggestions solely within New York State.*

### **Background on the Direct Pay Market in NY State**

The term "Direct Pay" is used to describe the market segment in New York State that provides insurance coverage to individuals who purchase their insurance coverage directly from a carrier. In 1991, in response to Empire Blue Cross and Blue Shield's severe financial hardship, then Governor Cuomo and the State Legislature enacted the Community Rating law in NY State that for the most part still govern the Direct Pay and small employer group (2 to 50) markets to this day. The 1991 law also gave commercial insurers -- but not HMOs -- the option to exit the Direct Pay market, which many did. leaving only Empire and HMOs in the market .

In 1995, the Legislature enacted a further change that mandated carriers in the direct pay market to provide both an HMO closed-network product and a POS out-of-network benefit product. The benefit designs of the two products were defined in the statute and modeled after the Empire BC/BS products. They feature low co-pays, no deductibles (except a limited one on pharmacy) and unlimited pharmacy coverage. The 1995 law remains in place today, virtually unchanged.

### **Current State of the Direct Pay Market – "A Death Spiral"**

In recent years, the Direct Pay market has seen steadily declining enrollment – down from over 110,00 to 57,000 as of March 2007. This has contributed to an unacceptably high number of uninsured in the state, although the number of uninsured has trended lower since 2003

Some of the decline was driven by the relative success of the HealthyNY (HNY) program for individuals at or below 250% of the federal poverty level (FPL), which provides a less comprehensive benefit package along with subsidies to generate much lower premium rates. As an example, the New York City rates for individuals in the Direct Pay HMO as of July 2007 range from \$501- 1,260 per month, while rates in the HNY (HMO) program are a more reasonable \$219-302 per month. But the increase in the HNY enrollment did not pick up the entire decline in the Direct Pay pool.

This dramatic decline in enrollment was mainly driven by individuals being priced out of the market, and as a result of the Health Care Reform Act of 2000 (HCRA 2000) public money was used to create a “stop loss” mechanism to stabilize rates. The mechanism reimburses carriers for claims that fall between \$20,000 and \$100,000. Carriers are reimbursed at 90% for these claims and this money was directly applied to reducing rates in this market. The initial funding provided in 2000 was sufficient to cover 100% of the claims liability, and was increased each year through 2003 to keep up with medical cost inflation. In 2004, the reauthorization of the Health Care Reform Act (HCRA II) eliminated this escalation, and the pool funding was frozen at \$40 million (\$20 million for HMO claims and \$20 million for POS claims). As a result of HCRA II, the stop loss pool now covers less than 50% of the claims liability and Direct Pay rates continue to climb.

As mentioned earlier, the benefit plans that were mandated by the 1995 legislation were comprehensive even under 1995 standards, with low office visit co-pays, comprehensive drug and medical coverage, no deductibles or co-insurance for the HMO and low levels for the POS plan when a member accessed out-of-network providers. Today, some twelve years later, these benefit designs remain unchanged and are not keeping up with the product dynamics that exist in the commercial employer-sponsored marketplace, which has reacted to increasing premium rates by developing plans that create consumer engagement and financial responsibility for their health care choices. The lack of product flexibility is one reason for the high cost of coverage for this market.

We are at the point in the Direct Pay market where the products being offered are unaffordable for the average individual. Carriers are left with a membership pool composed primarily of individuals who, because of either current or prior medical problems, have very high health care costs and must have health care coverage.

**Without an influx of premium dollars from healthier individuals with lower health care costs or additional public funding, this membership pool will continue down the classic “death spiral,” with healthier people being priced out of participation, and the sickest members remaining in the market because they must have coverage.**

## **UnitedHealth Group’s View**

We believe that true reform must be comprehensive and involve every set of constituents in the healthcare system. We cannot solve this crisis by focusing only on the financing of the benefit. Nor can we keep looking to public funds as band-aid solutions. We believe that healthcare reform must contain the following basic tenets:

### ***Reform should build on programs that work:***

- Reform proposals that build on successful marketplace solutions, including the creative public/private partnerships that exist now in Medicare, Medicaid and S-CHIP, are the right model for health reform.

- Employer-based health insurance coverage has long been the mainstay of health care coverage; 160 million Americans today receive health care coverage through employers. We support preserving this successful system.
- We do not support a “single payer” health care system, nor do we support a single minimum benefit package, as a general approach to reform. We believe that a market-based approach is essential if innovation is to flourish.

***Reform should be comprehensive:***

- If reform is to succeed, it must be comprehensive and touch all components of, and actors within, the health care system. All stakeholders share responsibility for the current situation and must play a role in reform efforts.
- We support efforts to encourage employers to provide health insurance and for individuals to obtain health insurance coverage.
- We support individual coverage mandates only if they are coupled with effective enforcement mechanisms. Mandates that are not enforced or are not enforceable will result in adverse selection, and will increase the cost of insurance coverage.

***Reform should improve the quality of care:***

- Adherence to evidence-based medicine and clinical best practices is a critical component of health care reform. Adoption of these standards is essential to ensuring that expanded coverage is effective coverage. These standards must include substantive information for providers and consumers about both the appropriateness and effectiveness of treatments and treatment settings.
- Individual responsibility for personal health management and the adoption of healthy behaviors are key ingredients for improving quality and accessibility of care. These behaviors should be encouraged through benefit designs.
- Enhanced public health education and management efforts on the part of federal and state governments are also essential to improving quality of care and the overall well-being of Americans.

***Reform should ensure cost-effectiveness:***

- To succeed over the long-term, health care reform must contain mechanisms to assure that health care dollars are spent effectively.
- Information about the relative costs and outcomes associated with particular treatments and treatment settings should be available to providers and consumers to improve their ability to make value-based health care decisions.
- Employers-Benefit Sponsors and third-party payers must have the ability to implement policies and programs that result in measurable savings without adversely affecting the quality of care or the availability of needed services.

***Reform should be funded through sustainable financing:***

- Expanded coverage must be financed through mechanisms that are sustainable over the long-term.
- Government funding for programs and individual subsidies should be broad based and not be funded through provider or premium taxes.

***Reforms should be phased-in to permit necessary adjustments:***

- Transition periods are essential to permit necessary adjustments in the behavior of providers, consumers, benefit sponsors and payers.
- Transition periods will enable employers and individuals to research and financially plan for changes in benefits, and will also permit real-time understanding of the effects of the reforms and allow for corrective actions.

**With this in mind, we offer the following specific suggestions on improving the Direct Pay and small group markets**

To begin with, we applaud the efforts of the Governor, Departments of Insurance and Health, Senate and Assembly Insurance Committee Chairs and the various stakeholders for re-examining the Direct Pay and Small Group markets as we develop a plan for universal health coverage.

***A new model of comprehensive coverage for the direct pay market:***

We propose creating a new risk pool for Direct Pay customers. To facilitate creation of the pool, we propose using the administrative structure of the state employee/retiree plan (NYSHIP). We do NOT recommend that the Direct Pay market be merged into the existing NYSHIP pool, but rather that the administrative structure and vendors of NYSHIP be used for a separate Direct Pay pool. Merging the Direct Pay market into the NYSHIP pool would lead to adverse selection and greatly increased costs for NYSHIP enrollees.

NYSHIP currently provides comprehensive health coverage to over one million state and municipal employees/dependents and retirees.

- A separate risk pool would be developed using the NYSHIP experience and unit costs as a basis.
- We present two rating options. Either the current community rating methodology or a modified community rating methodology based with broad age/sex bands. The latter would make the program more affordable to the younger aged who we know are reluctant to purchase any coverage let alone the expensive coverage currently available in the Direct Pay market.
- A new product suite for the Direct Pay market would be developed in collaboration with the agencies, departments and offices of New York State as well as the with NYSHIP vendors and the key stakeholders. This product suite would provide a broad continuum of prices and coverage, introduce wellness and

member compliance attributes, and provide for choice and policyholder engagement and responsibility. The program would stress the use of evidence-based medicine standards by participating physicians, providers and facilities.

- Although all NYSHIP program vendors would be used to administer this program, members would access coverage through the use of a single ID card.
- The financial mechanisms in place for reimbursement of claims expense of the NYSHIP program would be the same for this pool.
- The State may want to contract with a separate billing and reconciliation administrator to provide the necessary enrollment/premium intake.
- Premium rates could be established statewide or, if preferable, by region.
- Stop loss funding currently provided for the Direct Pay market would be used as one of the funding sources for this program. Ideally this stop loss fund would be funded more adequately than the current pool(s).
- All HCRA related surcharges would be eliminated for this population.
- We would recommend that as part of this proposal, the state evaluate the effectiveness of this proposal in comparison to other states' market structures in order to determine the best long-term solution to the direct pay market.

***Why the NYSHIP model for direct pay makes sense:***

- Provides for comprehensive access to necessary health care for all members of the Direct Pay market.
- Creates a more sustainable and affordable coverage for individuals without adversely affecting the small employer market.
- Prevents shifting the higher risk and costs of the Direct Pay market to the small employer market.
- Eliminates the need for all carriers to provide Direct Pay coverage.
- Allows for product innovation.
- Removes the variability from carrier to carrier of underlying medical economics in their networks.
- Establishes one set of medical management process and one network for the entire Direct Pay market.
- Provides the opportunity for a more thorough analysis of the Direct-Pay market.

***Foster flexibility and creativity in the small group market:***

We oppose any changes that would have further financial impacts on the small group market, which is struggling but dynamic and resilient, with competition in the Downstate region. By driving innovative products and broad choice with competitive premium pricing, we can further impact the growing uninsured problem.

We can fully strengthen the 1-50 employer sponsored market by allowing these employers to:

- Purchase Healthy NY at an unsubsidized cost;
- Provide these business with tax credits for their health insurance cost; and
- Encourage consumer engagement.

We believe steps like this will immediately help more small businesses provide health insurance coverage for their employees and prevent higher levels of working uninsured.

***Oppose merging the small group and direct pay markets:***

We strongly oppose merging the small group and direct pay markets:

- According the United Hospital Fund, the majority (52%) of uninsured workers in New York work for small businesses that are the life blood of our State's economic future. These small businesses are already struggling with the issues of affordable health insurance for their employees.
- Unless a successful, enforceable individual mandate is in place, community rating under a merged market will increase premium rates for small businesses to a degree that will make it impossible for them to continue providing affordable insurance for employees.
- We also don't believe reform that is based on redirecting perhaps as much as \$1 billion dollars from charity care is politically sustainable unless there is an equal reduction in the need for charity care.

**In Closing**

While our proposals require significant reforms we believe that they are politically achievable. We believe the best way of achieving these and other reforms is through the continued collaboration of government and the various stakeholders. UnitedHealth Group is firmly committed to participating in such a process.