

The *Big Picture* Snapshot Series

Since 2009, UHF's Health Insurance Project has been publishing *The Big Picture*, a series analyzing health plan enrollment and financial results in New York's private and public health insurance markets. The rollout of the Affordable Care Act (ACA) made 2014 a watershed year for New York's marketplace; we are examining the ongoing effects of the ACA with a series of snapshots highlighting specific issues related to it, as a complement to the forthcoming *Big Picture* chartbook on health plan operations.

Together, these briefs provide a fuller picture of issues and trends affecting the health insurance market since implementation of the ACA.

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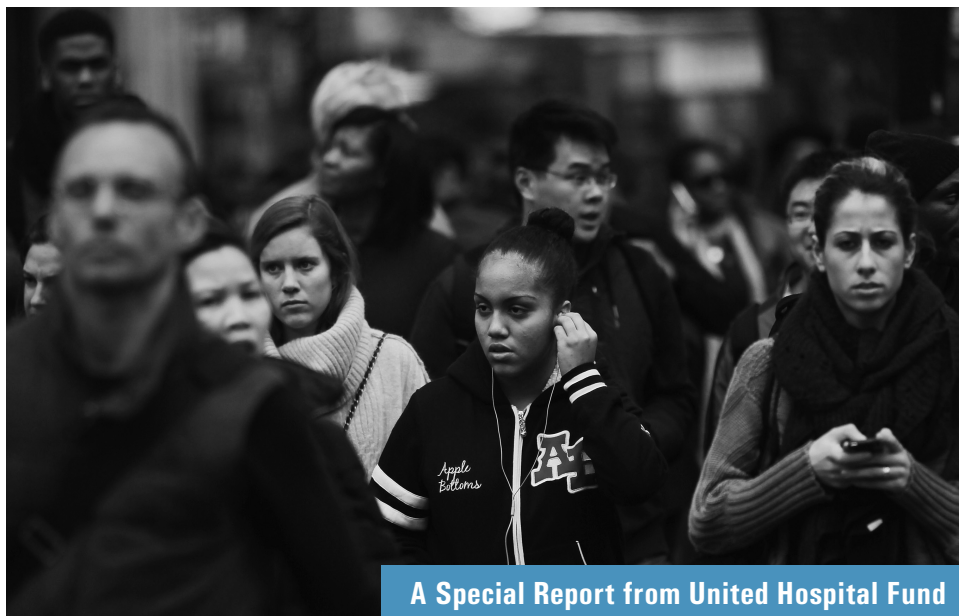
Affordable Care Act Brings New Life—and Covered Lives—to New York's Individual Market

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Introduction

As 2013 drew to a close, New York's individual commercial market limped along, the source of coverage for a dwindling number of individuals able to meet monthly premiums typically exceeding \$1,000 for the least expensive policy. In a telling sign of its distress, the market had become a key argument in the defense against legal challenges to the Affordable Care Act (ACA),¹ the prime exemplar of the need to pair insurance market reforms like those already in place in New York, with meaningful subsidies to individuals, and a mandate to purchase affordable coverage. This *Big Picture* snapshot provides an analysis of enrollment and financial data from the pre- and post-ACA individual markets, showing how New York's implementation of the ACA breathed new life into the individual market, and highlights some key areas of focus looking ahead.

Enrollment on the Rise

At the center of New York's remade individual market is its ACA Exchange or Marketplace, New York State of Health (NYSOH).² Annual enrollment reports from NYSOH provided the first signs of a revived individual market,³ but comparing 2014 enrollment in Qualified Health Plans (QHPs) through NYSOH and coverage purchased off-Exchange to a baseline representing comprehensive individual coverage reported by health plans in 2013 provides a more complete picture (Figure 1). Even when individual and sole proprietor members in Healthy NY (a separate public program) and estimated group association plan members are counted together with enrollment in the commercial individual market, individual

enrollment jumped from about 136,000 members in 2013 to almost 441,000 in 2014. Much of the new enrollment came from the 307,000 QHP members reported by health plans at the end of 2014, but enrollment in New York's individual off-Exchange market alone, with no premium and cost-sharing subsidies available, nearly eclipsed total individual enrollment in 2013.

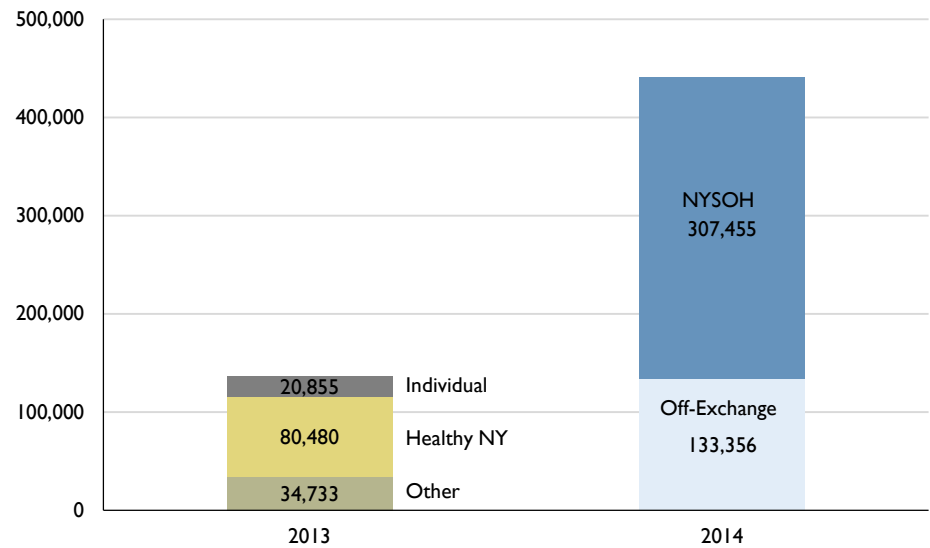
This larger group of individual market members also had more plans to choose from as competition increased in 2014. Eight new plans entered the commercial market in 2014.⁴ Five of the new plans—Affinity, HealthFirst, Fidelis Care, Metroplus, and Today's Options New York—are Pre-Paid Health Services Plans (PHSPs), specially licensed HMOs that had formerly offered only public program coverage. Besides offering a lower-cost option in many regions, these plans offered smoother transitions for individuals switching back and forth between Medicaid and QHP coverage due to changes in income or family circumstances; they also brought considerable experience to bear with low-income enrollees, having reported over 2.2 million Medicaid Managed Care members collectively in 2013. The remaining three plans were start-ups taking advantage of the opportunity that the ACA and Exchange created: North Shore-LIJ CareConnect, a provider-sponsored for-profit plan; Oscar Insurance Company, which focuses on using technology to improve the consumer experience; and Health Republic, formed under the ACA's new program for nonprofit cooperative insurers. Health Republic, however, whose low premiums attracted the highest enrollment in NYSOH, was required to shut down due to financial problems in 2015, creating significant turmoil. Today's Options withdrew from the Exchange for 2015.

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Figure 1. New York Individual Market Enrollment, 2013 and 2014



Source: NAIC annual statements, Supplemental Health Care Exhibits, New York Supplements, Medicaid Managed Care Operating Reports, NYSOH enrollment reports, and personal communication with the Department of Financial Services. See Sources and Methodology for additional detail.

Total Premiums Grew, but PMPM Premiums and Medical Expenses Declined

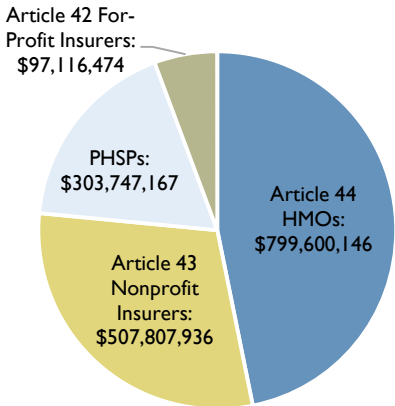
Total individual market premiums grew to over \$1.7 billion in 2014, with HMOs reporting nearly half of that total and PHSPs new to the commercial market recording over \$300 million (Figure 2). Compared to 2012,⁵ HMO individual market premiums more than doubled, from about \$381 million to nearly \$800 million.

But while the increased enrollment fueled higher overall premiums, monthly premiums and medical expenses for HMOs declined sharply from 2013 to 2014, when measured on a per-member per-month (PMPM) basis, as shown for three representative health plans (Figure 3): Empire BCBS (doing business as Empire HealthChoice Assurance HMO and Empire HealthChoice Assurance, Inc.), a leading individual market insurer before and after the ACA implementation, and two upstate plans,

Capital District Physicians’ Health Plan (CDPHP), and MVP Healthcare (MVP), which also garnered a large share of QHP enrollment in 2014.

Some of the decline in premiums and expenses can be attributed to the increased cost-sharing ushered in by the ACA, under which actuarial values—the percentage of expenses paid for on

Figure 2. Individual Market Premiums by License, 2014



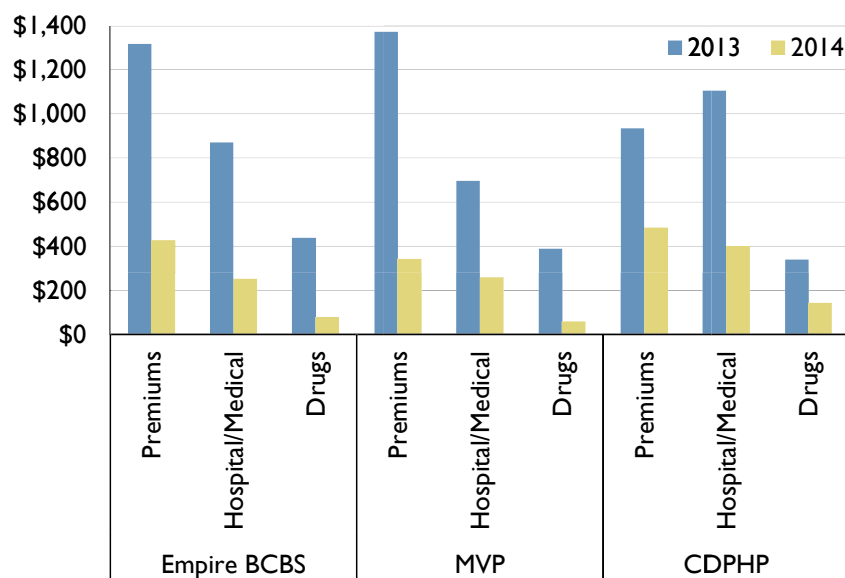
Source: New York Supplements and Medicaid Managed Care Operating Reports, 2014.

average by the health plan—range from 60 percent for bronze plans to 90 percent for platinum plans, compared to the very limited cost-sharing allowed for the standardized HMO products in 2013.⁶ Bronze rates for Empire BCBS in 2014 were \$360 per month, compared to \$616 for a platinum plan. Lower provider reimbursement rates for some QHPs may also have reduced expenses. But these factors alone don't explain the disproportionate drop in premiums and expenses.

Nearly 50,000 individuals in 2014 purchased platinum Exchange plans with actuarial values comparable to the 2013 HMO plans,⁷ not counting off-Exchange enrollees, and QHPs included benefits not provided in 2013, such as pediatric dental and vision coverage, habilitative benefits, and free preventive care. Nevertheless, health plans reported big drops in PMPM premiums, and expenses for hospital/medical care and drugs in 2014. At two plans, Empire BCBS and MVP, 2013 PMPM drug expenses were higher than premiums in 2014.

Empire BCBS reported \$872 in PMPM hospital/medical expenses in 2013, compared to \$253 in 2014, a 71 percent drop, and a decline in drug expenses from \$439 to \$81, an 82 percent reduction. CDPHP's 64 percent drop in PMPM hospital and medical expenses in 2014 reflects a pool of enrollees that grew from 394 direct pay members in 2013 to more than 4,000; MVP's 85 percent drop in PMPM drug expenses is certainly related to spreading those costs over just 211 members in 2013, and over 33,000 enrollees in 2014. But these premium and medical expense decreases show the impact of not just a greater number of enrollees, but also healthier ones, since a large group of enrollees with the same level of medical expenses would not change the PMPM equation.⁸ These declines also highlight the impact of enrollment that grew statewide, but is built on larger pools of members for each individual health plan, which they then use as the basis for calculating rates in a particular region.

Figure 3. PMPM Premiums and Medical Expenses at Three Large Plans, 2013 and 2014



Source: New York Supplements, Statement of Revenue and Expenses, 2013 and 2014.

Mixed Financial Results for Health Plans in 2014

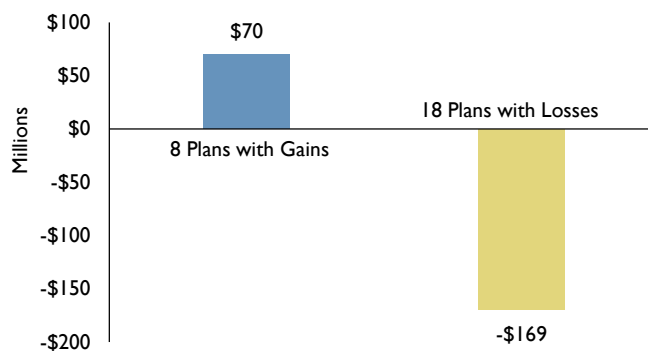
Larger enrollment and an apparently healthier risk pool did not translate to positive net income for most health plans in 2014. In a challenging year that required health plans and regulators to make educated guesses on the risk characteristics of enrollees in the remade market—and to address shifting guidance from federal regulators—losses totaled about \$100 million in the aggregate (Figure 4). However, eight licensees (several health plans participated in the market with more than one licensee) reported underwriting gains for individual coverage, including Empire BCBS HMO (\$30.1 million), Aetna Health Inc. HMO (\$16.0 million), HealthNow BCBS (\$5.8 million), and Independent Health Benefits Corporation (\$4.0 million). Two PHSPs, Fidelis (\$8.3 million) and HealthFirst (\$13,200) also finished in the black. Health Republic posted over \$38.1 million in losses in 2014, followed by HIP (\$36.4 million) and two of the other two new health plans, Oscar (\$27.5 million) and North Shore-LIJ CareConnect (\$23.0 million). Oxford Health Plans HMO, which operates only off-Exchange, reported \$6.1 million in losses for their individual business, but this was partially offset by the \$4.7 million gain by sister company

UnitedHealthcare HMO, the company's QHP on the individual Exchange.

A national analysis of financial results of commercial health plans⁹ reported an individual market underwriting margin of -6.1, about the same as New York's individual market in 2014.¹⁰ The same study found that severe losses by a small number of health plans were a significant factor in underwriting losses overall, and that the reduction in federal risk corridor payments—health plans received only about 13 percent of the loss reimbursement they would have received had the program been fully funded¹¹—was responsible for a 5 to 10 percent point change in net underwriting margins in states like New York, and disproportionately affected new health plans.

Individual market financial data for 2015 is not available for certain life insurers and all PHSPs, but partial results that included 2015 reporting for the remaining health plans show about a \$102 million overall loss in the individual market, again with winners and losers. Continued losses at Oscar Insurance Company (\$92 million) and NorthShore-LIJ CareConnect (\$23 million), new health plans, which typically do not turn a profit in their initial years of operation, when added to Health Republic's final

Figure 4. Individual Market Underwriting Gains/Losses, 2014



Source: New York Supplements and Medicaid Managed Care Operating Reports, 2014.

year loss (\$28 million) accounted for about three-quarters of the \$193 million in losses reported for 2015. Other plans reporting individual market losses were HIP (\$14 million) and Empire BCBS (\$33 million), which experienced almost the reverse of its 2014 results. Nine plans reported profitable years in 2015, including MVP Healthcare (\$17 million), Excellus BCBS (\$24 million), and Oxford HMO (\$13 million), as all three of these plans reversed losses they incurred in 2014. Results for PHSPs and some Article 42 insurers are not yet available.

Lower Premiums, Reinsurance, and Subsidies Made Coverage More Affordable

For many years in New York, annual individual premium increases far outpaced the offsetting effects of both a \$38 million state-funded reinsurance program,¹² and a risk-adjustment mechanism that provided a cross-subsidy from the small group market to the individual market, valued at \$62 million in 2009.¹³ In 2014, new enrollment, PHSP participation, more competitive pricing, a better risk pool, and a federal reinsurance program¹⁴ resulted in an average individual monthly premium of \$430.97 in New York.¹⁵ Only eight states had higher premiums, led by Wyoming (\$522.73), but among neighboring states, only Pennsylvania reported a lower monthly premium than New York's (Table 1).

These lower premiums made coverage more affordable for off-Exchange customers and the 25 percent of purchasers buying QHPs through NYSOH without federal financial assistance; the remaining three-quarters of QHP enrollees took advantage of Advanced Premium Tax Credits

(APTC), ACA premium subsidies for those earning less than 400 percent of the Federal Poverty Level (\$45,960 for single adults and \$94,200 for families of four, in 2014). Overall, APTC payments reduced premiums by an average of \$215 per month for the 74 percent of QHP enrollees receiving assistance in 2014 (Figure 5).¹⁶ As noted above, some of the decrease in premiums resulted from increased cost-sharing, but ACA cost-sharing reductions reduced out-of-pocket expenses for 57 percent of QHP enrollees, available to households earning less than 250 percent of the FPL (\$59,625 for a family of four in 2015).

New York policymakers took a further step toward increasing affordability for lower-income New Yorkers in 2015 by implementing the Basic Health Program (BHP) for eligible enrollees earning between 139 and 200 percent of the FPL for 2016; New York's BHP program is known as the Essential Plan (EP).¹⁷ As Table 2 shows, premiums are eliminated for individuals below 150 percent FPL, and cost-sharing is capped at \$200 annually. Compared to QHP subsidies, premiums are much lower for BHP enrollees between 150 and 200 percent FPL but cost-sharing is not reduced as significantly.

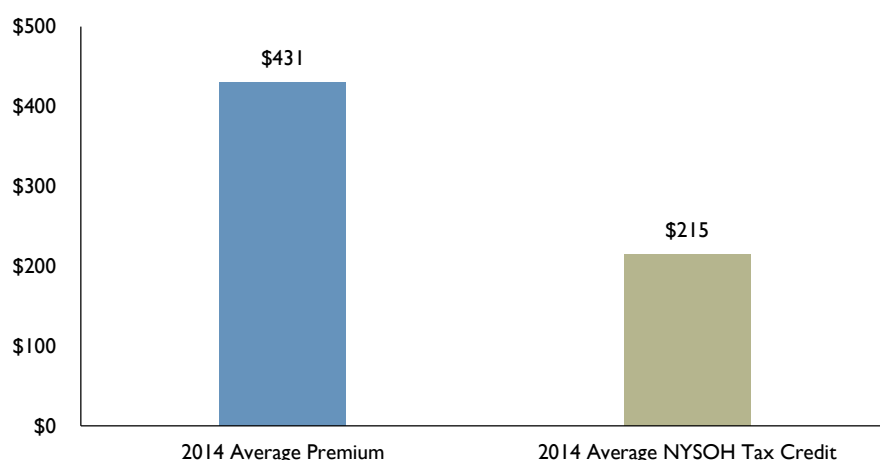
Table 1. Average Monthly Premiums in New York and Neighboring States, 2014

Pennsylvania	\$343.40
New York	\$430.97
Vermont*	\$439.17
New Jersey	\$460.36
Connecticut	\$461.23

*Vermont figure includes merged individual and small group markets.

Source: CMS. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, Revised September 17, 2015. www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

Figure 5. Individual Market Average Monthly Premium and Average QHP Subsidy for Eligible Enrollees, 2014



Source: CMS. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, Revised September 17, 2015. www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf. New York State of Health. June 2014. 2014 Open Enrollment Report. <http://info.nystateofhealth.ny.gov/2014OpenEnrollmentReport>

Table 2. Enrollee Cost-Sharing for Basic Health Program and Qualified Health Plans

	BHP at 139–150% FPL	BHP at 150–200% FPL	QHP at 150–200% FPL
Premium	\$0	\$20	\$129
Deductible	\$0	\$0	\$300
Maximum OOP	\$200	\$2,000	\$2,350
Inpatient Copay	\$0	\$150	\$250
PCP Copay	\$0	\$15	\$15
Drug Copay	\$1/\$3/\$3	\$6/\$15/\$30	\$9/\$20/\$40

Source: Cost-sharing based on NYSOH Invitation for 2017, Attachments B and G. QHP premium at 150–200% FPL based on NYSOH View Plans tool for the lowest premium, medical only, silver tier plan available to a Kings County resident earning \$24,000 annually (200% FPL). Drug copays represent categories for Generic or Tier 1/Formulary Brand or Tier 2/Non-Formulary Brand or Tier 3.

Discussion

The ACA changed New York’s individual market in many ways, creating a hybrid market with both subsidized and full premium coverage offered by both commercial and public program health plans, at prices often designed to capture market share, rather than avoid it. Several programs—Healthy NY programs for individuals and sole proprietors, and the Family Health Plus program expanding Medicaid eligibility—were phased out, and the requirement that HMOs offer a plan with an out-of-network benefit to

individuals ended in 2015. High Deductible Health Plans eligible for use with Health Savings Accounts, permitted only for individuals enrolled in the Healthy NY program in 2013, appeared on many health plans’ product menus in 2014. ACA Essential Health Benefits requirements enhanced benefits required under the standardized individual market rules in effect in 2013, but dental benefits, only offered through employer groups or as part of public program coverage, became widely available to individuals and families in the commercial market for the first time. Empire BCBS alone reported

standalone dental coverage for more than 70,000 individuals in 2015.¹⁸

The regulation of the market has evolved as well, as New York regulators and health plans adapted to a new federal partner and ACA rules. NYSOH, housed within the State Department of Health (DOH), joined DOH and the State Department of Financial Services (DFS) in administering these provisions—as well as ramping up electronic enrollment, eligibility, and shopping functions quickly; administering subsidies; soliciting participation; and running the Exchange. Because of ACA actuarial value requirements, New York regulators quietly suspended a decades-long ban on HMOs offering coverage with deductibles and coinsurance.

Overall, the individual market is in markedly better shape now than it was in 2013; the questions now are what steps will be necessary to sustain that improvement, and what factors could undercut these gains. Following are some areas worthy of focus.

A Stable Risk Pool. One issue that health plans have raised nationally¹⁹ in the context of the future viability of exchanges is the individual market risk pool, a crucial concern for New York, with its dysfunctional individual market risk pool still visible in the rear-view mirror. We’ve pointed out many signs of improvement; according to data released from the federal premium stabilization programs,²⁰ New York ranked 16th among states in 2014 in the “average plan liability risk score” used to distribute federal premium stabilization funds. With higher scores indicating older or sicker risk pools, Tennessee had the highest score at 1.958, and California had the lowest at 1.203. New York had a higher risk score than all neighboring states except Pennsylvania (Table 3). Updated data, expected later in 2016, will show how New York’s individual market risk pool changed in 2015.

Table 3. Risk Scores of Individual Market Risk Pools, New York and Neighboring States, 2014

Vermont	1.462 (merged market)
New Jersey	1.472
Connecticut	1.625
New York	1.691
Pennsylvania	1.900

*Vermont figure includes merged individual and small group markets.

Source: CMS. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, Revised September 17, 2015. www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

Retaining membership is one requirement for a stable risk pool. Enrollees often exit the individual market for job-based coverage or eligibility for public programs, but even so, NYSOH reported strong renewal rates in 2015—86 percent.²¹ But the planned transfer of QHP enrollees earning less than 200 percent FPL to the new BHP could adversely affect the risk pool, since this population must be pooled separately from the individual on- and off-Exchange market under federal rules. An extensive modeling study commissioned by New York State estimated a \$100 per year increase in individual QHP premiums if the BHP was adopted, and health plan 2016 rate filings reflected varying impacts of splitting off this group. Empire BCBS estimated in its filing that removing individual members eligible for the BHP in 2016 would increase the morbidity of the remaining market by 4.3 percent, and UnitedHealthcare HMO included a 3 percent upward adjustment for its individual premiums. In filings for 2017, MetroPlus noted a 24 percent increase in its index rate, a key building block in developing premiums, after removing its Essential Plan members, and Fidelis Care cites an “upward pressure on premiums” due to removing BHP members and their better claims experience from rate calculations.²²

Another factor that may be affecting the risk pool is the medical costs of consumers who enroll outside of regular annual open enrollment periods due to “qualifying life events” or other specified reasons.²³ After health plans cited higher medical expenses for these Special Enrollment Period (SEP) enrollees based on national data, along with indications that some of these policyholders dropped the coverage after accessing needed care,²⁴ federal regulators tightened the availability of SEPs.²⁵ California’s Exchange considered requiring enrollees to document eligibility, but after receiving input from consumer groups about barriers to enrollment and the difficulty of obtaining documentation of certain events,²⁶ it adopted a more measured approach,²⁷ including selective audits of SEP eligibility, examining ways to verify eligibility electronically, and studying off-Exchange documentation activities by health plans, which is permitted there. Currently, NYSOH relies mostly on attestation, though it requests documentation in some cases,²⁸ and health plans operating off-Exchange have limited ability to request documentation. Developing data based on the experience of New York’s SEP enrollees would help determine whether adjustments to the SEP process are warranted.

Room to Grow. In addition to retaining membership, continued growth will keep New York on the path toward its goal of universal coverage; growth is also crucial for maintaining a large, stable risk pool, the purest form of affordability subsidy. According to data not yet complete, in 2015 off-Exchange individual enrollment grew to over 208,000, QHP membership declined to 272,000, and BHP membership reached nearly 380,000, with the expectation that it might grow more,²⁹ since enrollment is year-round rather than limited to a single open enrollment period. BHP enrollment represents new members, but also individuals formerly covered by QHPs, and some former enrollees in the Medicaid Managed Care program.

Despite these gains, some analyses indicate that New York may still have room to grow. One national survey³⁰ estimated that New York’s Exchange had reached about 30 percent of state residents eligible for QHPs, about the national average; some states have enrolled about 50 percent of eligible residents. Census data for 2014 estimated that 284,000 New Yorkers between 138 percent and 199 percent of the FPL (the slice where ACA subsidies are deepest) were uninsured, along with 270,000 between the ages of 18-25, a highly prized demographic group due to their comparatively low costs, and over 314,000 were living in households earning \$100,000 per year or more. Both the new Basic Health Plan and ACA shared responsibility provisions—under which the penalty for not maintaining coverage rises to the higher of \$695 or 2.5 percent of household income—could help increase enrollment among these populations this year, but ACA tools are lacking for another major group lacking coverage, the estimated 629,000 noncitizens who were uninsured in 2014.³¹

Continued Affordability. More affordable premiums have been a key factor in the growth of the individual market. With the cycle for developing and reviewing rates for 2017 already begun, health plans and regulators face a difficult task. The loss of federal reinsurance payments will create an upward pressure on rates, and the absence of federal risk corridor reimbursement will also continue to reverberate. Those health plans that estimate the BHP will drain lower-risk individuals from their membership will need to include higher costs in their requests, and those health plans with negative returns in 2015 will seek to replenish surpluses, and stem losses. All of these factors will be added to the base rate calculation of “trend,” which projects premium rates based on expected utilization, and the price for covered services in the year ahead. Participation in the NYSOH Marketplace is a voluntary decision for health plans, another factor regulators must keep

in mind, and DFS will be under heightened scrutiny as it reviews rates, following Health Republic's insolvency.

Consumers with APTC subsidies will be shielded from most of the premium increases that may occur, but off-Exchange enrollees and NYSOH customers without subsidies could face significant monthly increases. A recent federal study³² found that, when taking into account the consumers who switched plans to limit rate increases, average monthly net premiums between 2015 and 2016 increased on federal exchanges by 8 percent for unsubsidized enrollees and by only 4 percent for consumers with premium tax credits. In New York, the Department of Financial Services (DFS) reported that for individual plans, the overall 10.4 percent increase sought by plans in the individual market was reduced to 7.1 percent for 2016, with more than half of that increase due to declining federal reinsurance, but next year's job will be even tougher, as DFS is considering an average weighted individual market rate increase from health plans for 2017 of over 17 percent.³³ Next year's premiums will be difficult to afford for many consumers, even if the increase granted is less than requested; this could significantly increase the financial burden of coverage for some who may already be feeling the pinch. One recent study³⁴ estimates that for individuals enrolled in nongroup coverage and earning between 300 and 500 percent of FPL (an income band in which the ACA provides no cost-sharing reductions and little or no premium assistance), premiums and out-of-pocket costs ate up 13.4 to 14.5 percent of income.

Given the history of New York's individual market, in which healthier enrollees fled as premiums rose to shockingly high levels, the affordability of premiums is the single biggest challenge facing the market, and it is inextricably linked to maintaining a healthier risk pool. This challenge is particularly pronounced for those

with modest subsidies or no subsidies at all. Steady premium increases, coupled with dissatisfaction about the levels of cost-sharing embedded in QHPs or more limited provider networks, could drive healthier enrollees to drop coverage, as those with higher health care needs cling to it, even if they must step down to a policy with lower premiums but higher cost-sharing.

Conclusion

Certainly, the results of the upcoming Presidential and Congressional elections could dictate a new path for states like New York that have embraced the ACA.³⁵ But even with ongoing federal support, New York still faces many challenges in the short and long term related to sustaining the momentum in its individual market: maintaining a large, stable risk pool; keeping markets competitive; improving affordability; devising strategies to tamp down cost drivers such as prescription drugs, for example, and control costs through value-based payments to providers; and better engagement of enrollees. New York has used all the tools in its kit for this individual market rehab—federal support for a new IT system, thousands of navigators and in-person assistors, discretion on rating rules and market mergers, certification standards for QHPs, standardized benefits and cost-sharing designs, rate reviews, and establishing the Basic Health Program. In the year ahead, State policymakers may want to consider another tool, the ACA Section 1332 Waivers for State Innovation.³⁶

States can apply for permission to waive certain provisions of the ACA beginning in 2017, and a handful of states have already begun work on their applications. Hawaii is seeking to move small employers back into its unique employer-sponsored system of coverage,³⁷ and California is considering allowing noncitizens to purchase

unsubsidized QHP coverage through its Covered California Marketplace.³⁸ For New York, a 1332 waiver, which can be sought in conjunction with Medicaid and Child Health Plus waivers, might help the State tailor ACA provisions to meet its own needs, such as the pooling of risks, coverage for noncitizens, and smoothing out “affordability cliffs” that crop up for consumers as they move from one level of subsidy to a less generous one.

Like mileposts on a highway leading to a desired destination, annual census data show the steady progress New York has made on reducing the numbers of the uninsured: 18 percent of the nonelderly were uninsured in 2002;³⁹ 15 percent in 2007;⁴⁰ 12.9 percent in 2009;⁴¹ 11 percent in 2013;⁴² 9 percent in 2014;⁴³ and, according to a preliminary estimate,⁴⁴ 5.7 percent were uninsured in 2015, prior to the completion of NYSOH’s Open Enrollment process for 2016. With the goal of near-universal coverage in sight, it is worthwhile to consider the experience of Massachusetts, the state whose health reforms provided the framework for the ACA and now

reports the lowest uninsured rate in the nation. An annual survey tracking progress and identifying areas needing attention cited continuing cost burdens for lower-income adults and those in poor health, and also difficulties with access to care and provider networks, even for those with health coverage, concluding that “the goals of health care reform are not fully achieved by simply reducing the number of people in Massachusetts who are uninsured.” This is a useful reminder for New York as it works to preserve the affordability of coverage and a stable risk pool, and as it opens a second front to tackle these issues related to access and value consumers seek in their coverage.

Acknowledgments

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Sources and Methodology

Enrollment figures for 2013, 2014, and 2015 are based on National Association of Insurance Commissioners (NAIC) Annual Statements; New York Supplements; NAIC Supplemental Health Care Exhibits; Medicaid Managed Care Operating Reports; and New York State of Health enrollment reports. For the 2013 baseline, Healthy NY enrollment for individuals and sole proprietors was provided by the Department of Financial Services through personal communication, Final Healthy NY Monthly Membership Information Report, Inforce Membership by HMO as of December 1, 2013. The “Other” category includes enrollment of 26,562 from the association plan operated by Freelancers Insurance Company, and 3,171 members in the federal Pre-existing Condition Insurance Plan, as of November 30, 2013, after the transfer of enrollment from the NY Bridge Plan to the PCIP.⁴⁵ We included an additional 5,000 members in the Other category to capture estimated enrollment in other association plans for which detailed enrollment data does not exist since it is reported on a group basis. We did not include enrollment in noncomprehensive hospital-only or basic medical coverage. Some Healthy NY members likely enrolled in the Medicaid program rather than QHPs because of their incomes. An unknown number of sole proprietors covered under group plans through small group association plans and paying an additional surcharge in premiums under New York rules probably gravitated to the individual market in 2014 after these arrangements were preempted by the ACA, but data on these groups is very limited.

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