A Financial Analysis of New York City Start-up Health Plans and Reasons for Their Losses

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ABSTRACT

Purpose: Using New York City as an example, this research explores reasons for the consistently poor financial performance of three start-up health plans (Health Republic, CareConnect, and Oscar) while other health plans have performed relatively well in the same market.

Design and Methods: This study compiles insurer data from financial years 2014 through 2016, submitted to the New York State Department of Financial Services as part of the rate-review process, including premium revenue, claims cost, risk adjustment, administrative costs, net income, and premium. The financial data were used to create a novel metric, adjusted net income, that evaluates the financial performance of an insurer excluding risk adjustment and assuming a market average administrative cost. Descriptive statistics were used to compare the performance of start-up plans, commercial plans, and Medicaid plans in the ACA exchange market.

Results: Premiums for start-up plans were within 9% of median silver premiums yet adjusted net income was negative (–$190 PMPM) for all three start-ups while it is positive (+$27 PMPM) for the non–start-ups. The difference in adjusted net incomes shows that poor financial performance of start-ups was due to claims costs, not high administrative costs and poor performance in risk adjustment.

Conclusion: The consistent financial losses by New York City start-ups is driven by higher-cost provider contracts for the start-ups relative to competitors.

INTRODUCTION

In 2014, New York City was widely considered an ideal market for the structured competition among health plans envisioned by the Affordable Care Act (Rabin 2013a). Large-market demand stemmed from a sizable self-employed labor force of independent consultants, artisans, and day-traders and artists, while market supply included robust Medicaid managed care and commercial markets, plus three brand-new start-up insurers. Table 1 (page 44) summarizes the 2014 exchange market structure including 10 plans, all with premiums far below 2013 individual market levels (Rabin 2013b).

Publicly available rate submission data show that New York City's start-up health plans, Health Republic, CareConnect, and Oscar, had disproportionately poor financial performance between 2014 and 2016 (NYS-DFS 2017).

Undercapitalization led Health Republic to a forced closure by the New York State Department of Financial Services (NYS-DFS) effective Nov. 30, 2015 (Waldholz 2016). CareConnect voluntarily ended individual contracts effective Dec. 31, 2017 (Lynam 2017). When CareConnect exited the market in 2017, its membership was not offered the chance to renew during the 2018 open enrollment period. When Health Republic closed, the membership was distributed to alternative plans.

Figure 1 (page 45) shows that between 2014 and 2016, Oscar accumulated losses of $182 per member per month (PMPM), totaling $235 million or 46% of its 2014–2016 revenue (see Table 3, page 47, for calculation). Those financial losses were larger than any other company in the New York City individual market except Health Republic.

The objective of this analysis is to better understand why start-ups in the New York City market performed poorly relative to traditional commercial plans and Medicaid plans entering the ACA exchange market in 2014.

METHODS

The NYS-DFS requires submission of aggregate historical financial data for each ACA exchange product for the most recent year available in Exhibit 17 of the rate submission (NYS-DFS 2017). Claims data are two years old, meaning rate submissions for the 2018 plan year contain data from 2016.

For this study, the NYS-DFS data for plan years 2016 to 2018 were compiled manually into a database. The database includes individual plans (on and off the ACA exchange) and the Essential Plan. (The Essential Plan was the name given to the Basic Health Program in New York. Under the ACA, states were allowed to set up Basic Health Programs that offered health plans for low-income people whose incomes were too high for them to be eligible for Medicaid). Financial data pertain to all counties where the plan participated, including those outside of the New York City rating region.

Five financial metrics were extracted from the DFS financial reports including total incurred claims, total

reinsurance, total risk adjustment, total administrative expenses, and premium revenue. These metrics were used to construct a new metric, net income, which is calculated this way: premiums – (total incurred claims + administrative costs + total risk adjustment + total reinsurance) (Figure 1).

Adjusted net income, shown in Figure 4 (page 46), is another new metric and is calculated this way: net income – (risk adjustment + administrative costs – average administrative costs for all plans). This metric was developed and applied because it compares the net income across health plans as if 1) risk adjustment did not exist and 2) administrative costs were the same across all health plans. This is important because it will show whether the poor financial performance of start-up plans is due to risk adjustment, administrative costs, or for some other reason.

Putting aside the complexities for a moment, the reasons for a health plan's poor financial performance can be grouped into four categories:

1. High risk adjustment
2. High administrative costs
3. Low revenue
4. High claims costs

This study included a financial analysis of each of these metrics to identify the driving factor for the closure of two of the three start-up health plans in New York. Strategic pricing below market price with the objective of acquiring share was considered, so a premium comparison was performed. Premium data were compiled from New York State of Health (NYSOH) data releases of average premiums by plan and region (NYS-DFS 2015, NYS-DFS 2016, NYS-DFS 2013). For simplicity's sake, the financial analysis is limited to the individual market only.

RESULTS

Risk adjustment

Risk adjustment is an ACA-required program where fully insured commercial health plans must submit information to CMS on the medical risk of their populations. CMS calculates the relative risk of each health plan's

Glossary of terms used in this article

Administrative costs: All nonmedical costs associated with a health plan, including but not limited to labor, rent, claims processing costs, and information technology.

Claims costs: All medical costs paid by the insurer, including hospital, physician, and pharmaceutical costs on behalf of members. Dental and vision costs may be part of claims costs if those services are covered.

Commercial health plan: A plan that has maintained a commercial insurance license and participated substantially in the individual and or group markets prior to 2014.

Individual market: Health insurance purchased by an individual, not through an employer.

Medicaid health plan: A plan entering the individual market that previously has exclusively or primarily offered insurance in government products, such as Medicaid or Medicare.

Medical management: Activities performed by a health plan to reduce patient medical expenses, such as requiring preauthorization for advanced imaging.

New York State Department of Financial Services: The department in New York State government that oversees insurance regulation and enforcement.

Per member per month (PMPM): Revenue and expenses in health insurance markets are frequently analyzed on a per member per month basis so they can easily be compared with premiums, which are generally calculated as per member per month payments.

Premiums: Monthly payments made by a beneficiary to a health plan. If a member is eligible for tax credits, this includes both the member share and the tax credit.

Rate submission: A New York State requirement that premiums be submitted to the Department of Financial Services of New York State with actuarial support in June for individual market insurance products sold in January of each year. The state can then approve, deny, or request modification of premiums.

Rental network: A network licensed by a health plan from another organization rather than having contracts written directly with the plan.

Risk adjustment: Federal program required for all plans participating in the individual market (on- and off-exchange) where health plans with a lower risk population relative to plans in the same market make a risk adjustment payment and plans with a higher risk population receive a risk adjustment payment.

Risk corridors: A temporary program created by the Affordable Care Act, effective 2014–2016, designed to collect profits above a certain level from successful plans and redistribute them to plans losing above a certain level. The program was initially guaranteed by the federal government, but this guarantee ended in 2015. Plans "owed" payments were paid pennies on the dollar for 2014 and nothing for 2015 or 2016.

Start-up health plan: A health plan that did not have a license to sell health insurance in the commercial or Medicaid markets prior to the start of 2014.

population. Plans with healthier-than-average populations make payments to plans with unhealthy populations throughout the state. Exhibit 3 shows that in 2016, the PMPM cost of risk adjustment for start-ups exceeded the cost for commercial plans but was far below the cost of risk adjustment to Medicaid plans. In addition, financial losses of start-ups far exceeded their risk-adjustment payments. Oscar's 2016 loss was $200 PMPM, of which $61 PMPM (30%) was due to risk-adjustment payments. Similarly, CareConnect's 2016 loss was $165 PMPM, of which $57 PMPM (35%) was due to risk adjustment (see Technical Appendix 1, pp 48–49, for calculation). This means risk adjustment played only a part of the poor financial performance of these start-up plans. Health Republic's risk-adjustment payment of $6 PMPM was about 1% of its massive $529 PMPM loss in 2015, its final year of participation in the New York State exchange.

Administrative costs

Figure 3 shows that start-up administrative costs in 2016 were higher than administrative costs of established plans—more than $100 PMPM for Health Republic and Oscar. The 2016 weighted average of the three start-ups' administrative costs was $104 PMPM while the weighted average of all other plans' administrative costs was $49 PMPM, meaning start-up administrative costs were an additional $55 PMPM more than competitor administrative costs. However, this additional $55 PMPM is only 28% of the 2016 losses of Oscar ($200 PMPM) and 34% of the loss of CareConnect ($165 PMPM). Note: Health Republic exited the market during 2015.

Revenue

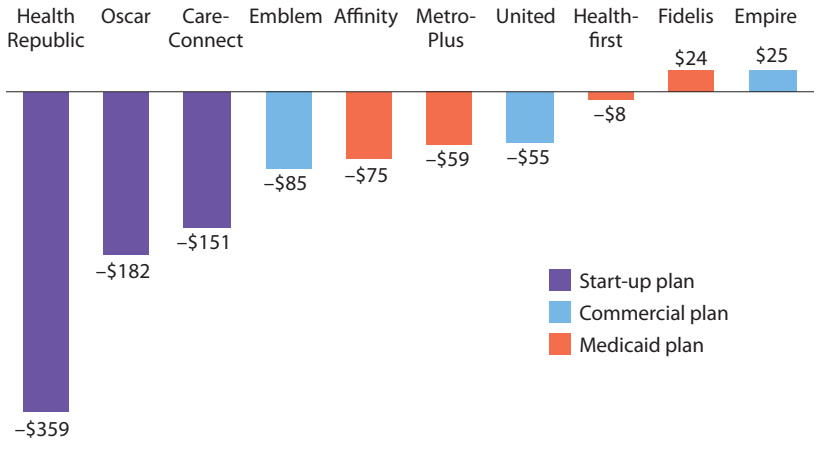
Table 2 (page 46) shows that the average premiums for plans at the silver level (the most commonly sold plan among the "metal" levels) of the three start-up plans between 2014 and 2016 ranged from 2% below the median to 9% above the median premium of $414 PMPM for a single adult be-

TABLE 1
Overview of New York City individual market plans

Plan name	Description	Enrollment (% of plans listed)	2018 status
Start-up			
Health Republic	Health Republic was an ACA CO-OP funded with federal loans	147,744 (17%)	NYS forced exit Nov. 30, 2015[a]
CareConnect	CareConnect, a subsidiary of Northwell the largest hospital system in New York State	52,298 (6%)	Exited market Jan. 1, 2018[b]
Oscar	Oscar, a pure tech venture aiming to apply Silicon Valley solutions to health insurance	107,569 (12%)	Expanded into N.J., Calif., Texas, Tenn., Ohio[c]
Medicaid			
Affinity	Bronx-based Medicaid plan	24,600 (3%)	Exited individual market in 2018[d]
Fidelis	Catholic Church-affiliated plan: purchased by Centene for $3.75B in Sept, 2017[e]	161,431 (18%)	Offers coverage
Healthfirst	Health plan owned by a consortium of New York City regional hospitals	52,601 (6%)	Offers coverage
MetroPlus	Health plan owned by the City of New York	62,454 (7%)	Offers coverage
Commercial			
Emblem	Regional commercial plan insuring NYC employees	62,233 (7%)	Offers coverage
Empire BCBS	Anthem-owned, for-profit Blues plan in NYC region	191,895 (22%)	Redeveloped products in 2018[f]
United	National commercial plan	21,755 (2%)	Offers coverage

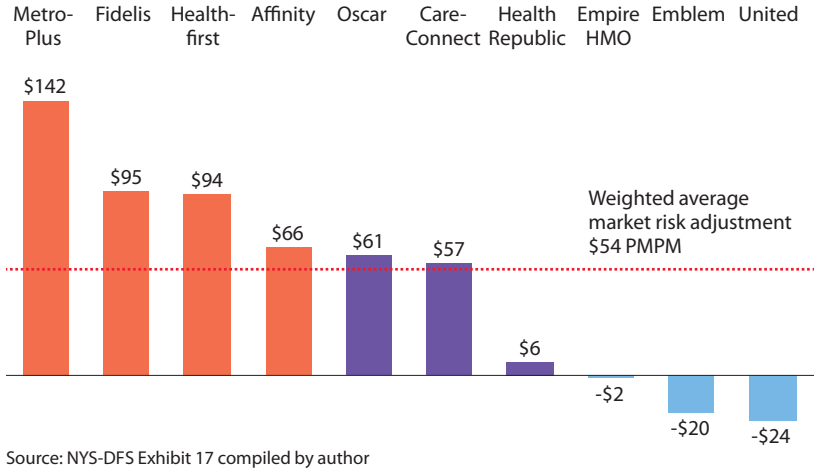
Sources: [a]Waldholz 2016, [b]Lynam 2017, [c]Schlosser 2017, [d]NYS-DH 2017, [e]Coombs 2017, [f]Schreiber 2017 and author's analysis of health plan websites
Notes: Queens County had the largest enrollment in the New York City Exchange Plan region and was used as the base county for determining health plan participation. Start-ups are defined for this paper as insurers that had not previously offered insurance in the individual market or in New York's Medicaid Advantage market as prepaid health service plans.
BCBS=Blue Cross Blue Shield, CO-OP=Consumer Operated and Oriented Plan, NYC=New York City, NYS=New York State.

FIGURE 1
Net income (individual market) for 2014–2016 PMPM



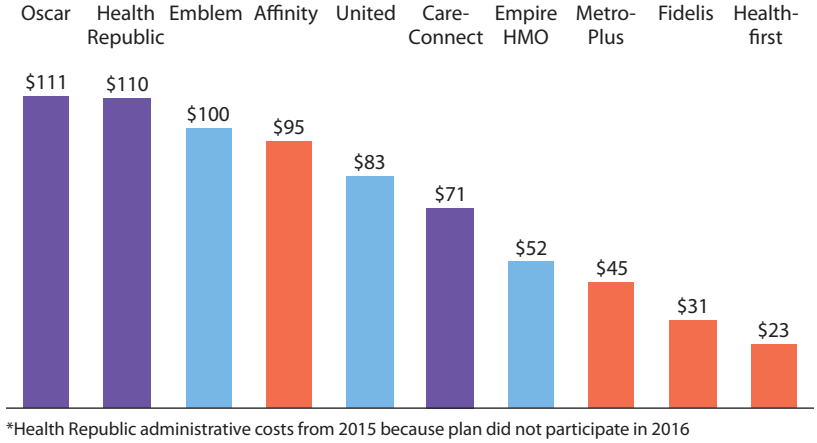
Source: NYS-DFS Exhibit 17 compiled by author

FIGURE 2
Risk adjustment PMPM in 2016



Source: NYS-DFS Exhibit 17 compiled by author

FIGURE 3
Individual market administrative costs PMPM 2016*



*Health Republic administrative costs from 2015 because plan did not participate in 2016
Source: NYS-DFS Exhibit 17 administrative costs compiled by author. PMPM=per member per month

tween 2014 and 2016. Premiums for other metal levels may vary.

Adjusted net income

Figure 4 shows adjusted net income (Net income – [risk adjustment + administrative costs – average administrative costs]) for all plans were –$83 PMPM at CareConnect, –$86 PMPM at Oscar, and –$305 PMPM at Health Republic. Meanwhile, adjusted net income of all other plans was +$27 PMPM.

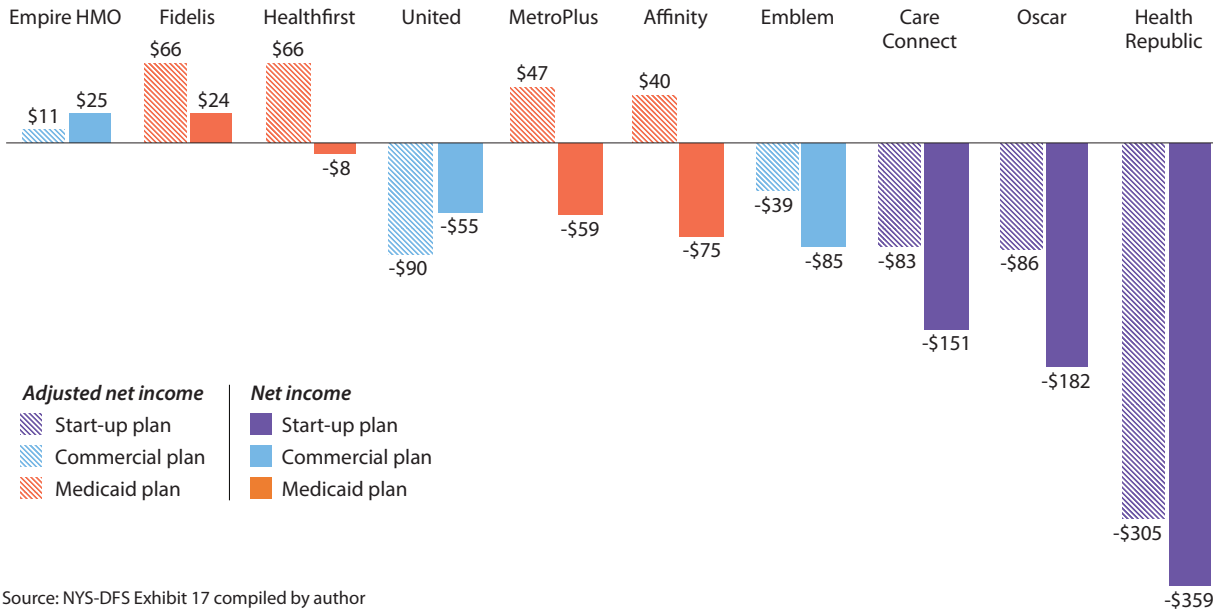
DISCUSSION

The financial data, which are all publicly available but never have been compiled and analyzed in this way, show the key driver of the disproportionately poor financial performance of start-up plans in New York City was neither risk adjustment nor administrative costs nor premiums, so therefore, losses must be primarily driven by provider claims costs.

Risk adjustment

While CareConnect and Oscar leadership both directly attributed their poor financial performance to the risk-adjustment program (Goldberg 2016, Lynam 2017), this analysis of the data shows that risk adjustment was responsible for only about 30% of the net loss of these plans in the individual market. In addition, while start-ups have less experience in risk adjustment, the program is a level playing field for all plans because the rules of risk adjustment are created by CMS as a part of the formal regulatory development process, including a comment period and rule finalization (CMS 2014). The rules of risk adjustment were available for all the players in the market in advance of the start of the plan year, making the practical application of risk adjustment equal across all plans, although there is some anecdotal evidence that newer plans have performed poorly (Goldberg 2016).

FIGURE 4
Adjusted and unadjusted net income PMPM total, 2014–2016



Source: NYS-DFS Exhibit 17 compiled by author

Three start-up health plans had a combined net income of –$966 million, of which $158 million (16%) was due to risk adjustment. Non–start-up health plans had a net income of –$46 million in spite of making $338 million in risk adjustment payments. Therefore, while risk adjustment may be a contributor, it is not the sole driver of poor financial performance. While this paper focuses on the individual market, CareConnect faced a 2016 risk adjustment payment of $112 million in the small-group market, and although plans can enter or exit markets independently, the small-group market payment played a role in the decision in the individual market (Dowling 2018).

TABLE 2
Average silver plan premiums from 2014–2016 in New York City region

Health plan	Rank	Average silver plan premium 2014–2016	Premium relative to median ($414)
United	1	$579	39.9%
Empire HMO	2	$498	20.3%
Oscar	3	$449	8.6%
Healthfirst	4	$420	1.5%
Emblem	5	$416	0.5%
Health Republic	6	$412	–0.5%
CareConnect	7	$407	–1.7%
Affinity	8	$403	–2.6%
Fidelis	9	$394	–4.8%
MetroPlus	10	$370	–10.5%

Source: NYS-DFS premium releases

Administrative costs

Similarly, the results section showed that start-ups had administrative costs of $104 PMPM while non-start-up health plans had administrative costs of $49 PMPM, a difference of $55 PMPM. Net losses for start-ups exceeded $150 PMPM, so excess administrative costs were only about a third of those net losses.

Relatively high administrative costs for start-up health plans are expected because start-up health plans have large initial administrative costs, including developing claims processing systems, building work facilities, licensing insurance products, training new staff, and developing a provider network. In addition, initial enrollment may be small while established health plans can distribute fixed costs across a broader membership. Therefore, the administrative costs per member of health plan start-ups was expected to be higher than the administrative costs of established plans, but the excess administrative costs made up only a third of the losses, meaning a large portion of the loss was unrelated to this expected expenditure.

TABLE 3
Net income as a proportion of premium

Plan	Sum of member months	Sum of total premiums ($)	Sum of net income ($)	Sum of % net income of premium	PMPM ($)
Affinity	295,199	107,917,557	–22,110,421	–20%	–75
CareConnect	627,571	257,547,975	–94,774,476	–37%	–151
Emblem	746,795	322,185,003	–63,839,792	–20%	–85
Empire HMO	2,302,745	1,105,591,889	56,571,839	5%	25
Fidelis	1,937,176	697,921,470	46,653,626	7%	24
Health Republic	1,772,932	818,192,488	–636,187,001	–78%	–359
Healthfirst	631,215	259,013,426	–5,202,112	–2%	–8
MetroPlus	749,442	292,386,663	–44,313,356	–15%	–59
Oscar	1,290,830	508,835,581	–235,206,464	–46%	–182
UnitedHealthcare	261,061	145,510,703	–14,485,621	–10%	–55

PMPM=per member per month.

Revenue

Table 2 shows that start-up health plan premiums were within 9% of the market median, so the prices the start-ups plans charged were competitive; they did not egregiously underprice their premiums to gain market share. Healthfirst, Fidelis, and MetroPlus—plans sold primarily in the Medicaid market—were financially stable between 2014 and 2016 at a premium similar to what the start-ups charge.

Claims costs

Figure 4 shows that after controlling for administrative costs and risk adjustment, start-up health plans still had disproportionate financial losses. This suggests that in New York City, start-up health plans had a systemic issue leading to persistent financial losses in addition to high administrative costs and poor performance on risk adjustment. Financial data from the New York City individual market health plans show that start-up plan premiums were in the same range as established plan premiums, yet insufficient to cover costs even after adjusting for risk adjustment and above-average administrative costs. Therefore, the financial performance issues are due to claims costs.

Here are three possible explanations for why claims could be higher for start-ups:

- **The health of the start-up population was worse.**
  It is unlikely that all three start-ups selected for worse risk while simultaneously having low risk-adjustment scores, indicating the populations had better than average risk.
- **Medical management was less effective at start-ups.**
  The magnitude of any possible medical management differential is dwarfed by the financial losses, which are in excess of 35% of premium revenue for each start-up.
- **Start-up networks were more expensive.**
  The most likely reason for the poor financial performance of the start-up plans in New York City is start-up plan networks were expensive. The high cost may include a broader network or contracts with higher reimbursements for all providers. Both Oscar and Health Republic licensed a rental network called MagnaCare, which was known for having high reimbursement rates, providing some evidence that network contract costs drove start-ups' poor financial performance (Fischer 2014, Waldholz 2016). Oscar recognized the provider network as a driver of loss and redesigned its strategy, shifting away from rental networks for years 2017 and beyond. While still unprofitable in 2017, its loss was $64 million, or $124 PMPM (down from $200 PMPM in 2016), and Oscar's New York business had its first profitable quarter in Q1 2018.

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CONCLUSION

Starting a health plan is difficult. Of the three 2014 start-up health plans in New York City, one closed during 2015 and another closed after 2017. Only Oscar remains, and it racked up cumulative losses of $235 million from 2014 to 2016 (NYS-DFS 2018).

Although administrative costs and risk adjustment contributed to financial losses, expensive network contracts were the critical driver in the poor financial performance of these start-ups. Success of the exchanges can be enhanced by improving the environment for programs like risk corridors that reduce risk to plans. At the same time, start-ups must recognize that efficient network contracts are essential for financial success.

TECHNICAL APPENDIX 1

Grouping of companies with varying names

Technical Appendix 1 shows how company names that varied in financial statements from year to year were aggregated. For example, North Shore–LIJ CareConnect Insurance Co. Inc., CareConnect, and CareConnect Insurance were all aggregated into CareConnect.

Part I: Health plans in financial statements	
Company names*	**Company name grouped**
Affinity	Affinity
Affinity Health Plan Inc.	Affinity
CareConnect	CareConnect
CareConnect Insurance	CareConnect
CDHP-Grp. HSA	Empire HMO
CR-GR-PPO.A/Rev	Empire HMO
Empire HealthChoice HMO Inc.	Empire HMO
Empire HealthChoice HMO Inc.	Empire HMO
EPO SG INN Cert 0407	Empire HMO
EPO SG INN Cert 0407 with rider: R-Prism EPO-SG.Rev0110	Empire HMO
G-HMO-IN with OON contract: G-POS-OUT	Empire HMO
Health Insurance Pla	Emblem
Health Insurance Plan of	Emblem
Health Republic Insurance of New York	Health Republic
Healthfirst PHSP Inc.	Healthfirst
HNY HMO-CERT-44; HNY HMO-CERT	Empire HMO
HNY HMO-CERT-44B; HNY HMO-CERT-B	Empire HMO
MetroPlus	MetroPlus
MetroPlus Health Plan Inc.	MetroPlus
New York State Catholic	Fidelis
New York State Catholic Health Plan Inc. dba Fidelis Care New York	Fidelis
North Shore–LIJ CareConnect Insurance Co. Inc.	CareConnect
NY State Catholic Health	Fidelis
Oscar	Oscar
Oscar Insurance Corp.	Oscar
R-EPO-Blue Essential 2011	Empire HMO
UnitedHealthcare of New	UnitedHealthcare
UnitedHealthcare of New York Inc. (UHC)	UnitedHealthcare
*The plan names, include some incomplete names, are how as they appeared on financial statements examined by the author.	

Part II: Health plans in premiums table	
Company*	**Grouped name**
AETNA LIFE	Aetna
AFFINITY	Affinity
AMERICAN PROG	American Progress
ATLANTIS	Atlantis
NORTHSHORE LIJ	CareConnect
CDPHP HMO	CDPHP
GHI	Emblem
HIP HMO	Emblem
HIPIC	Emblem
EMPIRE HMO	Empire
EXCELLUS	Excellus
NEW YORK FIDELIS	Fidelis
FREELANCERS	Health Republic
HEALTHFIRST	Healthfirst
HEALTHNOW	HealthNow
IHBC	IBC
METRO PLUS	MetroPlus
MVPHP-HMO	MVP
OSCAR	Oscar
OXFORD HMO	United
UNITED	United
North Shore LIJ	CareConnect
CDPHP	CDPHP
Crystal Run HP	Crystal Run
Emblem HIP	Emblem
Empire Assur.	Empire
Fidelis (NYS Cath)	Fidelis
Health Republic	Health Republic
MVP HP	MVP
Oxford OHP	United
UHNY	United
Wellcare	Wellcare
CDPHP UBI	CDPHP
EMPIRE BCBS	Empire
IHA HMO	IHA
MANAGED	Managed
METROPLUS	MetroPlus
MVP SERVICES	MVP
MVPHP2HMO	MVP
OXFORD OHI	United
Aetna	Aetna
Crystal Run HIC	Crystal Run
HealthNow NY	HealthNow
Managed Health	Managed
United HIC	United

*Variations in the spelling of names reflect their appearance in the financial statements examined by the author.

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TECHNICAL APPENDIX 2
Net income by plan in 2016 only

Plan Name	Sum of net income without risk adjustment and avg admin costs of plan	Sum of net income	Sum of net income PMPM	Sum of net income without risk adjustment and avg admin PMPM	Sum of total premiums	Sum of member months
Empire HMO	$10,568,160	$21,863,496	$30	$14	$428,191,738	734,880
Fidelis	$36,672,069	–$3,752,340	–$6	$55	$250,214,045	670,296
Healthfirst	$3,990,025	–$4,364,044	–$27	$25	$70,324,097	162,270
MetroPlus	$5,522,697	–$21,155,503	–$96	$25	$85,237,821	219,694
Affinity	–$3,936,974	–$11,655,717	–$143	–$48	$31,037,143	81,464
Emblem	–$18,847,336	–$20,860,521	–$143	–$130	$72,212,446	145,388
UnitedHealthcare	–$14,391,876	–$13,805,591	–$144	–$150	$50,484,767	96,127
CareConnect	–$35,674,392	–$57,534,599	–$165	–$102	$144,905,455	348,549
Oscar	–$67,179,599	–$144,574,167	–$200	–$93	$289,633,058	724,467

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