

## **Partnership for Coverage**

### **Modeling of Options for Expansion of Health Insurance Coverage for New Yorkers**

#### **Call for Public Comment**

This document describes the modeling instructions that will be given to the State's contractor, The Urban Institute, to model proposals to expand health insurance coverage in New York. Although the enabling legislation does not require that the modeling instructions be made available for public comment, the Departments of Health and Insurance (collectively, "the Departments") believe that such comment will better inform the policy development process. Comments on the modeling instructions may be submitted to [partnership4coverage@health.state.ny.us](mailto:partnership4coverage@health.state.ny.us). Individuals may also submit written comments to New York State Insurance Department, Partnership for Coverage, Suite 1700, One Commerce Plaza, Albany, New York 12257, or New York State Department of Health, Partnership for Coverage, Empire State Plaza, Corning Tower, Room 2001, Albany, New York 12237. Comments must be received by July 21, 2008.

#### **I. Introduction**

In July 2007, the Governor directed Health Commissioner Richard Daines, M.D., and Insurance Superintendent Eric Dinallo to study the obstacles to health coverage in New York and to develop, evaluate and recommend proposals for achieving quality, affordable health insurance for all New Yorkers, building on reforms already undertaken.

Important progress has already been achieved with the enactment of State legislation to expand Child Health Plus, streamline enrollment in government sponsored health programs, allow employers and unions to buy-into the Family Health Plus (FHP) program, expand consumer protections under managed care, rationalize the Medicaid system and promote primary and preventive care. These reforms represent significant first steps that New York can build on, despite some attempts by the federal government to block their implementation.

Over the past year, the Departments, as part of the Governor's Partnership for Coverage initiative, have reached out broadly to the general public, stakeholders in the health care system, academic experts and other states engaged in universal coverage initiatives. Public hearings were held from September to December 2007 in Glens Falls, Buffalo, Manhattan, Syracuse, Rochester and Old Westbury. In addition, a call-in hearing was held for those who could not attend the public meetings. Through testimony from 280 people at the hearings and meetings with more than 60 stakeholder groups, the Departments heard the concerns and experiences of consumers, employers, providers and insurers engaged in our health care system. Many stakeholders and health policy experts highlighted proposals for health reform. In addition, those closely involved in current universal coverage initiatives in Massachusetts, Maine and California shared their experiences and lessons learned in developing and implementing comprehensive

health system reforms. All of this input has provided tremendous insight into the issues related to health insurance coverage in New York State.

As part of the Partnership for Coverage initiative, the Departments have also been directed to model the cost and coverage implications of various proposals for achieving universal coverage in New York State. The 2007/2008 New York State budget appropriated funding for a consultant to assist with the modeling. The Departments issued a request for proposals and the Urban Institute was awarded a contract, finalized in March 2008, to provide in-depth analysis of policy and financing options. The Urban Institute has extensive experience and a sophisticated simulation model.<sup>1</sup>

This document outlines the modeling process including the methodology used, the proposals selected for modeling and the specific parameters to be incorporated into the proposals. The instructions described herein reflect only a starting point for evaluation. The modeling process is dynamic and will take place in stages over a number of months. The final report will include a complete description of all modeling results and assumptions.

## **II. The Modeling Process and Methodologies**

Although no process exists that can predict the full impact of broad health policy changes with 100 percent accuracy, micro-simulation modeling is the best tool available to estimate the impact of various health reform proposals on cost, coverage patterns, employers, consumers and overall health care spending. Similarly, a macro-simulation model can be used to estimate how reforms would impact New York's current economic environment. The quantitative modeling results will help to predict the consequences of various health reform proposals and their components and allow for effective comparison across proposals.

### **A. The Health Insurance Policy Simulation Model (HIPSM)**

The Urban Institute's micro-simulation model, Health Insurance Policy Simulation Model (HIPSM), will provide answers to a variety of questions including:

- How do different reforms affect the number of uninsured?
- How do employers and workers respond to changes in the cost of health insurance under various subsidy arrangements?
- How do insurance market reforms affect risk pools?

HIPSM is particularly well suited to examine reforms that affect multiple sectors of New York's healthcare system because HIPSM is sensitive to how employees' expected health care costs affect employers' decisions. The HIPSM micro-simulation model has three main components: (1) a state-specific baseline database; (2) a reform module and (3) a behavioral module.

**State-Specific Baseline Database.** The Urban Institute is developing a New York specific baseline database that reflects New York's current demographics, distribution of health insurance coverage, distribution of health expenditures, premium rates and out-of-pocket costs.<sup>2</sup>

**Reform Module.** HIPSM's reform module will next apply key aspects of the health insurance reforms to the simulated individuals and employers in the baseline database. The reform module implements changes in the set of available options and computes the costs of alternative coverage types under reform. The module computes the changes in premiums and out-of-pocket costs that individuals and employers would face as a result of policy changes, such as the introduction of subsidies or changes in public program eligibility. The introduction of new options and prices creates the potential for examining changes in coverage status, which are implemented in the behavioral module.

**Behavioral Module.** The last component of the HIPSM model is the behavioral module which computes how individuals and employers will respond to changes in the set of available coverage options and prices. The nature and magnitude of these effects is grounded in the health economics literature.

## **B. The Regional Economic Model Incorporated (REMI)**

Since the HIPSM model does not assess the impact of health insurance reform upon the economy of the State, the Urban Institute will use Regional Economic Model Incorporated (REMI), a dynamic simulation model designed to assess the macro-economic impacts of policy reforms. This type of analysis has proven very useful to policy development. An assessment of the macro-economic impact of health reforms provides answers to critical questions about how reforms will impact various stakeholders including the business community.

The REMI macroeconomic simulation model draws on econometric equations, input-output models and computable general equilibrium models to produce state-specific economic and demographic forecasts. Economic impacts are calculated by sector, industry, and/or occupation based on an evaluation of demand for: employment and capital; population and labor supply; wage rates; prices and profits; local and export market shares and final output. REMI also incorporates interactions between regional, national and international economies. REMI's macroeconomic model is based upon a database of historic and recent economic data.<sup>3</sup>

## **III. Reform Proposals Selected for Modeling**

The 2007/2008 New York State budget specified that the models to be examined must include at least: a model based on existing private and public health coverage mechanisms; a publicly-sponsored health coverage model financed entirely or largely through broad-based public financing and a combination of both mechanisms.<sup>4</sup> Based on extensive public input and discussions with the Urban Institute, the Departments have prepared modeling instructions for four different proposals to expand health coverage to New Yorkers:

- Single Payer "Medicare-for-All"
- New York Health Plus
- Combined Public-Private Reform
- The Freedom Plan

In keeping with the charge given to the Departments, each proposal will be analyzed for its ability to: rapidly provide health coverage to the citizens of New York; control the cost of health insurance and health care; fairly and equitably distribute the cost of health insurance and health care; improve the State's economy and the competitiveness of the State's businesses; promote the economic viability of health care providers and embrace increased use of preventive medicine to improve quality and reduce health care costs.

To maximize our ability to compare proposals to the greatest extent possible, a number of common parameters have been identified in each model. Maintaining continuity across models makes it possible to test the sensitivity of the proposals across assumptions. This will allow for effective determinations as to whether variations in results are caused by differences in the proposals as opposed to differences in a particular key feature such as the target population or benefit package.

**Target Population.** Each proposal will be modeled to include all New York residents who do not qualify for Medicare. This includes all citizens, legal resident non-citizens and undocumented non-citizens.<sup>5</sup>

**Public Programs.** Medicare, Medicaid, Family Health Plus (FHP), and Child Health Plus are assumed to continue to serve, at a minimum, their existing populations with the benefit packages that currently exist for each program.<sup>6</sup>

**Benefit Package.** The FHP benefit package, modified to include full mental health parity, will be used in proposals that include a comprehensive benefit package (i.e., Medicare-for-All, New York Health Plus and Combined Public-Private Reform). This allows for effective comparison of other variables across models. Other benefit packages may be modeled in the future.<sup>7</sup>

**Cost Outlook.** The overall cost of each proposal will be modeled one, five and ten years out to assess the intended and unintended costs to consumers, employers and government over time. The cost analysis will also estimate any savings attributable to the unique features of each system and the impact of the proposal on New Yorker's available resources.

**Financing.** The Urban Institute has advised that financing mechanisms should be modeled after the reforms are modeled and cost analysis is complete. While financing mechanisms and possibilities for redirection of existing resources will be examined in the future, the employer assessment in the combined public-private proposal is included for examination at this time in order to estimate coverage and cost effects correctly.

**Cost Containment.** Though many of the proposals include cost containment features, the micro-simulation model is unable to capture much in the form of cost containment. This is largely due to a lack of empirical evidence demonstrating the impact of cost containment strategies. Such data is currently emerging as government and health plans test various approaches to achieving cost containment. The Departments are aware of the importance of identifying and implementing cost containment strategies for both public programs and private health insurance. Health reform will be virtually impossible without a clear agenda to curb the unsustainable rise in health costs, especially given increasingly bleak economic indicators. The

extent to which increases in health care costs can be contained will be a key factor in our ability to expand access to health insurance coverage in the State. Discussion and analysis of cost containment initiatives will be addressed in the final report.

#### **IV. Proposals to be Modeled - Details and Policy Combinations**

Each of the proposals and the assumptions included in the initial modeling instructions are set forth below.

##### **A. Single Payer “Medicare-for-All”**

The single payer “Medicare-for-All” proposal implements a single, government-run, health care financing system in New York. This proposal establishes a “universal financing” system, as opposed to a “universal health care” system. As with Medicare, doctors are not government employees and hospitals are not government run.<sup>8</sup>

The proposal includes the following key components:

- All New York State residents are entitled to a standard set of benefits.
- The health insurance benefit package is comprehensive.
- Health risks are broadly pooled across the New York State population.
- Hospitals and clinics operate within global budgets.
- Non-institutional providers are reimbursed on a fee-for-service basis.
- The financing system is administered by State government.
- Private health insurers have no role.
- Coverage is financed through a broad-based progressive mechanism.

##### **Single Payer Modeling Parameters**

**The Plan.** The Single Payer proposal assumes that all private health insurance is eliminated in the State and that a State agency is established to administer a single payer option in New York. The agency is responsible for implementing eligibility and enrollment, adopting benefit packages, setting health care expenditure budgets, negotiating reimbursement rates, overseeing consumer disputes, engaging in health care facility planning, administering provider payments, measuring quality and facilitating uniform electronic medical records.

**Benefit Levels.** The model includes the FHP benefit package with full mental health parity. Adjustments to the FHP benefit package may be examined.

**Provider Payments.** Hospitals and institutional providers are paid according to a global budgeting methodology designed to contain costs and encourage appropriate utilization. Other providers have the option to be paid on a fee-for-service basis or elect a capitation rate. Enrollees can choose to enroll in integrated delivery systems paid on a risk adjusted basis.

##### **B. New York Health Plus**

Designed and advanced by Assembly Member Gottfried, New York Health Plus is a publicly sponsored, publicly-funded health plan.<sup>9</sup>

The proposal assumes the following key components:

- All residents are entitled to a defined set of health benefits.
- Coverage is standardized and comprehensive.
- Coverage is delivered through private health plans under State contract.
- A publicly operated fee-for-service option is available.
- Health risks are broadly pooled across the population.
- A broad, progressive tax applies to finance coverage.
- Employers and individuals can purchase coverage outside of the State-contracted plans.
- Employers and individuals can obtain a partial credit against their broad-based tax liability for amounts they have invested in private insurance.

### **New York Health Plus Modeling Parameters**

**The Plan.** The New York Health Plus proposal assumes FHP coverage is available to all New Yorkers through managed care plans under contract with the State. The State pays the full premium. In addition, insurers can offer the coverage through traditional fee-for-service, preferred provider organizations (PPO) and point of service (POS) arrangements. Health plans compete for enrollment based on network and customer service. A competing publicly run fee-for-service option, like traditional Medicare, is also available offering full choice of health care providers.

**Benefit Levels.** The FHP benefit package, modified to include full mental health parity, will be used. The modeling assesses the impact of imposing no deductible and only minimal coinsurance requirements upon enrollees.

**Choice of Private Coverage.** Private coverage and supplemental coverage remain available for purchase in New York State. Employers and individuals that continue to purchase private coverage in lieu of participating in New York Health Plus are eligible for a partial credit to offset their broad-based health insurance tax liability. The initial modeling run assumes the credit to be 80 percent of expenditures on private coverage, not to exceed an amount equal to 80 percent of the State's cost for New York Health Plus.

**Provider Payments.** Providers can organize and collectively negotiate with health plans.

### **C. Combined Public-Private Proposal**

The Combined Public-Private Proposal builds on New York's existing healthcare infrastructure. The proposal relies on simplification and expansion of existing public health insurance programs combined with reforms to improve the function of New York's private health insurance markets.

The proposal assumes the following key components:

- Public health programs are simplified to maximize enrollment.
- Public health programs are expanded.
- Private market reforms are introduced to increase affordability and accessibility. The market reforms to be examined include:
  - Establishment of a health insurance exchange,
  - Merger of New York's individual and small group markets,
  - Introduction of a public program buy-in,
  - Adjustments to community rating,
  - Introduction of sliding scale subsidies,
  - Imposition of an individual mandate.
- Employer based coverage is retained.
- Costs are shared between government, employers and households.
- Federal funding is maximized.

### **Combined Public – Private Modeling Parameters**

**The Plan.** The Combined Public-Private proposal builds upon the current public and private health insurance systems. The proposal assumes a strong push toward enrolling the large segment of the uninsured that are currently eligible, but not enrolled, in public programs. The proposal then expands existing public programs to individuals with incomes above current eligibility levels. Market based reforms designed to enroll New Yorkers in private coverage are then layered on top of the public program reforms to extend coverage to those that remain ineligible for public programs. The cost and coverage implications of direct premium subsidies, indirect premium support mechanisms, employer assessments and a mandate on individuals to enroll in health insurance are tested under this proposal.

**Public Program Simplifications.** While public program simplifications are not easily amenable to micro-simulation modeling, assumptions regarding the cost and coverage impact of a group of enrollment simplifications are included. The proposal assumes that the State leverages the new statewide enrollment center authorized in the 2007/2008 New York State budget and currently under development. When in place, the enrollment center will have the capacity to operate a consolidated and centralized hotline, develop and run telephone renewal, accept new applications and manage aspects of the existing FHP buy-in and premium assistance programs. Additional simplification strategies to be analyzed include: maximization of auto-enrollment and auto-renewal in public health programs through the use of existing data from other programs; elimination of face-to-face interviews at initial application; elimination of the finger imaging requirement for single and childless couples; less frequent renewals (e.g., every two years) and consolidating categorical eligibility.

**Public Program Expansions.** The proposal expands public programs to reach those in need of coverage at higher income levels as follows:

**Family Health Plus.** The proposal expands eligibility for FHP to a single standard applicable to single adults, childless couples as well as parents with children. Two scenarios will be modeled: (1) Expansion of FHP eligibility to a single standard of

160% of the gross federal poverty level (FPL); and (2) expansion of FHP to a single standard of 200% FPL.

**Child Health Plus.** An expansion of New York’s Child Health Plus program up to 400 percent of the federal poverty level, funded exclusively with State dollars was authorized in 2008. Since this expansion is a critical “building block” of the Partnership for Coverage initiative, the baseline for the model incorporates the Child Health Plus public program expansion.

**Market Reforms.** The impact of three separate market reforms will be evaluated. These include a merger of New York’s individual and small group markets; establishment of a health insurance exchange and introduction of a public program buy-in option.

**Merger of Individual and Small Group Markets.** This reform requires all insurers and health maintenance organizations (HMOs) in New York’s small group market to extend their small group insurance products to individuals. Individual and small group claims experience is merged into a single claims experience pool. Individuals and small groups are charged the same premium rate. The initial modeling run assesses the impact of introducing modified age rating and expanding the size of small groups to include employers with up to 99 employees.

**Establishment of a Health Insurance Exchange.** This reform introduces a health insurance exchange which serves as the point of contact for purchasing individual and small group health insurance products. The exchange actively negotiates rates with participating insurers and administers any available State subsidies. The initial modeling run considers the establishment of an exchange for employer groups with up to 50 employees, and for all employers. The impact of limiting all individual and small group health insurance sales to the exchange (assuming no competition outside of the exchange) is also examined. New York State employers are assumed to be required to offer Section 125 plans to permit the use of pre-tax dollars in paying premiums through the exchange.

Standardized health insurance benefit packages are offered within the exchange. In the initial phase of modeling, the FHP benefit package, modified to include full mental health parity, is the standard package. Future modeling runs will introduce additional standardized benefit packages ranging from comprehensive to high deductible health plans. The impact of offering a competing public option within the exchange and a discrete “young invincible” product designed to reach adults under the age of thirty will be tested in future runs.

**Introduction of a Public Program Buy-In Option.** This reform allows individuals, small groups or large groups to buy-in to the FHP program. There are three alternatives to this reform: no pooling of the claims experience of buy-in participants with the claims experience of existing Medicaid expansion participants; separate pooling of employer/individual buy-in participants and full pooling with existing participants (this option would require a change in federal position).

Establishment of a buy-in to the New York State Health Insurance Program, the employee benefits plan for State employees, as well as to the Healthy NY program may be included in future modeling runs.

**Premium Support Mechanisms.** Two scenarios for premium support mechanisms to assist with availability and affordability are included -- direct premium subsidies and the application of State-funded stop-loss or reinsurance.

**Direct premium subsidies.** The initial run assesses phasing in premium subsidies for coverage offered through the exchange or through a public program buy-in option. The premium subsidies are set at levels that make coverage more affordable for New York residents. Determining the percentage of household income that should be directed towards health insurance premiums necessitates a social and political judgment based on the best available evidence. The schedules below illustrate two options to be modeled for total monthly medical costs (premiums and out-of-pocket) as a percent of income.<sup>10</sup> Based on output, additional variations may be examined.

**Schedule 1.**

Percent of Federal Poverty Level	Percent of Family Income
Below 160%	0%
160 – 200%	6%
200 – 250%	8%
250 – 300%	10%
> 300%	12%

**Schedule 2.**

Percent of Federal Poverty Level	Monthly Cost/ Percent of Family Income
Below 160%	No cost
161 – 225%	Individuals \$18 (1.4%), Families \$45 (1.6%)
226 – 250%	Individuals \$30 (1.6%), Families \$75 (2%)
251 - 300%	Individuals \$50 (2.4%), Families \$125 (2.9%)
301 - 350%	Individuals \$70 (2.8%), Families \$175 (3.4%)
350 - 400%	Individuals \$100 (3.5%), Families \$250 (4.1%)
400 - 500% %	Individuals \$140 (4.3%), Families \$350 (5.1%)
500 - 600%	Individuals \$200 (4.7%), Families \$500 (5.8%)
> 600	Individuals \$253 (≤ 4.9%), Families \$632 (≤6.1%)

**State-Funded Stop-Loss/Reinsurance.** This premium support mechanism assumes that the State will reimburse health plans for a percentage of claims paid on behalf of high-cost enrollees in order to spread risk and stabilize premiums. This reform includes two scenarios

for increasing or applying State-funded reinsurance: (1) to all individual and small group products; and (2) to a public health insurance buy-in option.

**Individual Mandate.** The proposal is assessed with and without an individual health insurance mandate requiring New Yorkers to enroll in insurance or face sanction.

**Employer Health Care Contribution.** The proposal is evaluated with and without a broad-based employer assessment to support the health care of New Yorkers. Modeling will test the impact of assessing employers six percent of payroll, subject to a credit against that assessment for the value of health coverage employers choose provide to their employees.<sup>11</sup> Modeling will examine the impact of the assessment assuming three situations: (1) the assessment applies to all employers and workers; (2) employers with less than 25 employees are exempt from the assessment, and (3) part-time workers are exempt from the assessment. Based on output, additional variations will be examined.

The employer health care assessment is included at this time to determine its impact on retention of employer sponsored coverage. A range of options for full financing of this proposal will be evaluated in the future.

#### **D. The Freedom Plan**

The Freedom Plan promotes private markets to address health insurance coverage needs.<sup>12</sup>

The proposal includes the following key components:

- The availability of high deductible health plans (HDHPs) is increased.
- Health insurance benefit mandate requirements are eliminated for HDHPs.
- Community rating requirements are adjusted.
- The availability of Healthy NY is expanded.
- State-funded stop-loss or reinsurance is increased.
- A 50 percent State tax credit is introduced.

#### **Freedom Plan Modeling Parameters**

**The Plan.** The Freedom Plan relies on HDHPs, expansion of Healthy NY, relief from health insurance benefit mandates, reduced regulatory requirements and adjustments to community rating. The proposal also offers tax credits and additional stop-loss assistance to health plans.

**Freedom Policies.** The Freedom Plan introduces “Freedom Policies” or HDHPs to New York’s individual health insurance market. When coupled with Health Savings Accounts (HSAs), HDHPs are exempt from New York’s benefit mandates. The plan also provides rating flexibility for “Freedom Policies” allowing similar, but different policies within a community pool to be rated separately.

**Healthy NY.** Healthy NY is expanded under the Freedom Plan. Eligibility limits for individuals covered under Healthy NY are increased from 250 percent to 300 percent gross FPL. Individuals

and small groups that do not meet the eligibility requirements are permitted to buy-in to Healthy NY at full actuarial value. The proposal increases the emergency co-payment for Healthy NY from \$50 to \$100 and the annual cap on prescription drug coverage from \$3,000 to \$5,000. An additional layer of stop-loss protection is added to Healthy NY, reimbursing HMOs for 90 percent of claims paid in excess of \$500,000 on behalf of Healthy NY enrollees in a given calendar year.

**Direct Pay Stop-Loss.** Direct pay stop-loss coverage is expanded using two approaches. The first approach assumes full funding of the existing direct payment stop-loss pools applicable to the New York individual standardized market. The second approach introduces an additional layer of stop-loss protection to reimburse HMOs for 90 percent of claims paid in excess of \$500,000 on behalf of direct payment enrollees in a calendar year.

**HMO Regulatory Flexibility.** The Freedom Plan permits HMOs to establish minimum participation levels for large group policies and to refuse to write large group coverage if the other benefit packages offered by a group are likely to promote adverse selection. The proposal also allows HMOs to offer products in the large group market subject to the same deductibles, coinsurance and co-payments requirements as non-HMOs. Due to a lack of data, however, the Urban Institute is unable to model the impact of changes to introduce such regulatory flexibility for HMOs.

**Tax Credits.** The proposal includes a State tax credit for 50 percent of the cost of health insurance premiums paid by individuals and small groups with 50 or fewer employees. Although the Freedom Plan incorporates a non-refundable tax credit, it is not possible to model a non-refundable tax credit using HPSM. This is due to a lack of sufficient data regarding the tax liability of individuals and small groups eligible for the tax credit. However, it is possible to model the application of a “refundable” tax credit because the credit available to the eligible population would equate to the cost of their health coverage. For this reason, modeling will test inclusion of a refundable tax credit. The Freedom Plan phases in the tax credit over ten years. Modeling will show the impact of a fully phased-in credit.

## V. Next Steps:

Public input has been instrumental in the development of the proposals to be modeled and will continue to play a critical role in the development of recommendations for reform. Written comments on the modeling instructions are invited and may be submitted to [partnership4coverage@health.state.ny.us](mailto:partnership4coverage@health.state.ny.us). Individuals may also submit written comments to New York State Insurance Department, Partnership for Coverage, Suite 1700, One Commerce Plaza, Albany, New York 12257, or New York State Department of Health, Partnership for Coverage, Empire State Plaza, Corning Tower, Room 2001, Albany, New York 12237. Comments must be received by July 21, 2008.

It is anticipated that the modeling will be completed in Fall 2008.

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<sup>1</sup> [www.urban.org](http://www.urban.org)

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<sup>2</sup> The core microdata file which defines the model's population base is a matched version of the March 2005 Current Population Survey (CPS) Annual Social and Economic Supplement, the February 2005 CPS Contingent Work and Alternative Employment Supplement, and the 2004 Statistics of Income (SOI) public use tax file. The March CPS is the main source of demographic characteristics and insurance coverage; the February CPS contains information on employer-sponsored insurance (ESI) offer and worker eligibility that are not available in the March file. The SOI, a stratified random sample of 150,047 unaudited tax returns representative of the population of returns filed for tax year 2004, provides detailed information on the forms filed, the income earned, and the tax computed for each record. Wherever possible, Urban Institute will link CPS records across the February and March surveys. For observations in the March CPS without a corresponding observation in the February CPS, Urban Institute will impute values for health insurance offer and eligibility. Observations from the augmented CPS file are statistically matched to the SOI. This core file has been weighted to reflect the rates of insurance, both overall and by family income level. The Urban Institute will "grow" these data to 2008, the base year of analysis in the model by first aging the core microdata to match the most recent March CPS (data-year 2006), and then applying growth rates in combination with demographic and aggregate targets to age the data to 2008.

<sup>3</sup> Full approval and execution of the Insurance Department's piggyback contract with the Urban Institute is needed in order to allow for use of the REMI model or any additional HIPSM modeling runs which exceed the dollar amount of the Department of Health's primary contract with the Urban Institute.

<sup>4</sup> [www.budget.state.ny.us](http://www.budget.state.ny.us)

<sup>5</sup> The target population for initial modeling includes both citizens and non-citizens in response to public input. However, the costs associated with inclusion of non-citizens will be identified and examined in the future.

<sup>6</sup> Extensive discussions between the Departments and the Urban Institute focused on the best approach for modeling existing public programs. It was concluded that modeling should assume that the Medicare population continues to be served by Medicare. Continued incorporation of the Medicare program maximizes federal financial support of the health care needs of New York's elderly population. Targeting the non-elderly population is also consistent with the terms of the RFP that resulted in a contract with the Urban Institute. Additionally, it was decided that initial modeling runs should assume that Medicaid, Child Health Plus and Family Health Plus continue to serve their eligible populations. This approach maximizes federal financial participation and retains a rich level of health benefits for New York's low-income Medicaid eligible population. Consistency in assumptions regarding public programs across proposals will permit effective comparison of results.

<sup>7</sup> Based on extensive public input and availability of cost data, the FHP benefit package was selected as a starting point for modeling proposals that incorporate a comprehensive benefit package. The consistent use of the FHP benefit package in the initial modeling will allow for effective comparison of proposals. It is anticipated that a wide variety of benefit packages will be considered in future modeling runs.

<sup>8</sup> To the extent feasible, the parameters for the single payer proposal are based upon input from single payer advocates. Consideration was given to the "specifications of single payer options" submitted by Physicians for a National Health Plan (PHNP).

<sup>9</sup> To the extent feasible, parameters for the New York Health Plus proposal were selected to be consistent with the proposal outlined by Assembly Member Richard Gottfried. <http://assembly.state.ny.us/mem/?ad=075>

<sup>10</sup> Two divergent affordability schedules were selected as a starting point for analysis. The first schedule was developed based on research conducted by the Urban Institute. See L. Blumberg, J. Hadley, J. Holahan, K. Nordahl, "Setting a Standard of Affordability for Health Insurance Coverage," Health Affairs, June 2007. The second schedule was developed by the Community Service Society. See E. Benjamin, Testimony. Partnership for Coverage Public Hearing. Long Island, NY. December 5, 2007. [www.partnership4coverage.ny.gov](http://www.partnership4coverage.ny.gov)

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<sup>11</sup> The proposed six percent employer assessment is included in the model as a starting point for analysis. Notably, six percent is lower than the estimated average eight percent contribution from employers offering individual health insurance benefits. See United Hospital Fund, “A Blueprint for Universal Health Insurance Coverage in New York,” 2006, <http://www.uhfny.org>.

<sup>12</sup> To the extent feasible, the parameters of the Freedom Plan are consistent with a proposal that has been under legislative consideration for several years, currently sponsored by Assemblyman Morelle (A.2524). The Freedom Plan components reflect public input from market reform advocates, who favor expanded access to high deductible health plans, increased regulatory flexibility, reduced benefit mandates, expansion of Healthy NY and tax credits.