

Cornerstone for Coverage *Program Specifications*

Two and a half million New Yorkers under age 65 are uninsured. More than 2.1 million of these uninsured individuals are between the ages of 19 and 64, representing 18% of the total adult population. If implemented, the Cornerstone for Coverage proposal would offer high-quality, affordable health insurance on a sliding-scale to all uninsured New York residents regardless of immigration status. Uninsured New Yorkers with income up to \$61,400 (single adults) or \$103,000 (family of three) would be eligible for subsidized coverage. Individuals and families with income above these limits would be able to purchase coverage at full cost. Employees and members of businesses and unions could participate through a subsidized buy-in program.

As the nation and New York enter fiscally difficult times, the Cornerstone for Coverage is an incremental, but viable, approach to universal health care, providing universal *access to* health coverage. The Cornerstone for Coverage builds on New York’s extremely popular public insurance programs—Child Health Plus and Family Health Plus—which offer affordable, high-quality health insurance through a choice of insurance plans and comprehensive benefits, with no hidden costs or onerous mandates. It is important to note that New York’s model Child Health Plus program was adopted as the blueprint for the nation’s SCHIP program which today provides coverage to millions of American children. The Cornerstone for Coverage proposal once again provides a historic opportunity for New York State to assert its leadership role in the formation of national health policy.

I. “Cornerstone for Coverage” Program Specifications

A. Cost and Enrollment Projections Summary

The Cornerstone for Coverage proposal is a cost-effective approach to providing universal access to affordable coverage for all New Yorkers. Over the first five years following implementation of the Cornerstone for Coverage, CSS estimates that the program will enroll over 1.8 million New Yorkers, 888,000 of whom were previously uninsured, for as little as \$2.6 billion.

Coverage for these 1.8 million adults and children would cost the state and federal governments a total of \$4.47 billion in the fifth year following implementation.

	Number of New Uninsured Enrollees	Total New Enrollees	Total Government Cost (millions)	Assuming <i>Maximum</i> Federal Share		Assuming <i>Minimum</i> Federal Share	
				NY Cost	Federal Cost	NY Cost	Federal Cost
Year 1	177,584	360,400	\$673.5	\$415.4	\$258.1	\$673.5	\$0
Year 2	355,167	720,799	\$1,448.9	\$897.5	\$551.4	\$1,448.9	\$0
Year 3	532,751	1,081,200	\$2,333.9	\$1,451.2	\$882.7	\$2,333.9	\$0
Year 4	710,334	1,441,600	\$3,336.6	\$2,081.9	\$1,254.6	\$3,336.6	\$0
Year 5	887,918	1,801,999	\$4,465.7	\$2,795.4	\$1,670.4	\$4,465.7	\$0

Families would contribute \$1.5 billion, and employers would contribute roughly \$200 million.¹ With maximum possible federal matching funds, New York State could bear as little as \$2.8 billion of the total program costs associated with the Cornerstone for Coverage in the fifth year following implementation.

Cornerstone for Coverage: Total Federal and State Costs, Year 5 (dollars in millions)					
	Total Government Cost	Government Costs Assuming <i>Maximum</i> Federal Share		Government Costs Assuming <i>Minimum</i> Federal Share	
		NYS Cost	Fed Cost	NYS Cost	Fed Cost
Adults	\$4,428.5	\$2,782.4	\$1,646.2	\$4,428.5	\$0
Children	\$37.2	\$13.0	\$24.2	\$37.2	\$0
Total	\$4,465.7	\$2,795.4	\$1,670.4	\$4,465.7	\$0

B. Key Programmatic Features

The Cornerstone proposal would create universal access to health insurance by: (1) expanding subsidized health coverage for uninsured adults in New York State ages 19 to 64 with sliding scale premiums; (2) permitting individual adults and families above subsidy level to purchase coverage at full cost; (3) extending coverage to New York State resident adults regardless of immigration status; and (4) aligning family coverage by continuing the expansion of sliding scale premiums for children above 2007-2008 proposed Child Health Plus B (CHPlus B) eligibility levels.²

Eligibility

This proposal builds on the successes of Family Health Plus and Child Health Plus in New York State. Eligibility criteria related to age, state residency and enrollment in other insurance would apply to this new eligibility group, as follows:

- Must be under the age of 65;
- Must not qualify for coverage under existing public health insurance programs;
- Must be a permanent resident of New York State; and
- Must not have other health insurance coverage as defined currently under FHPlus and CHPlus B.

Currently, immigration status is not considered when determining eligibility for CHPlus B, but is considered when determining eligibility for FHPlus or Medicaid. Only adult citizens

¹ Cost and enrollment projections do not include the cost and enrollment of the currently eligible uninsured, or enrollment of individuals and families buying in to coverage at full premium cost. Estimates also assume that the CHPlus B expansion has occurred, and that public insurance simplification and streamlining issues have been addressed.

² An underlying assumption of this memo is that the CHPlus expansion up to 400% of FPL will be implemented by the State and that the Cornerstone program will extend eligibility to children with family income between 400% and 600% of FPL.

and lawful immigrants (including those considered Permanently Residing Under Color of Law (PRUCOLs)) are eligible for FHPlus or Medicaid. Given that immigrants constitute 30% of New York’s uninsured, the Cornerstone for Coverage proposal extends coverage to all adult immigrants who meet the other eligibility criteria outlined above.³

Benefit Package

The FHPlus expansion would offer the same benefit package to adults in the new eligibility group as is currently offered under FHPlus, including coverage for the services described below:

- Inpatient hospital care
- Outpatient primary and preventive care
- Emergency services
- Prescription drugs
- Behavioral health and chemical dependence services (with limits)
- Long term health care services (with limits)
- Durable medical equipment
- Dental
- Vision
- Reproductive health services

Children in the new eligibility group would be offered the same benefit package as is currently offered through Child Health Plus.

Enrollee Cost Sharing

The Cornerstone for Coverage incorporates a fair “what you see is what you get” philosophy of cost-sharing – progressively-staged co-premiums, with low co-payments and no deductibles. This framework means that virtually all of a family’s health care costs are paid up-front. Removing complex and confusing cost-sharing structures means that families face no hidden costs. At the same time, a significant portion of the overall cost of coverage is offset by family co-premium contributions, significantly decreasing the up front costs of the program for the State.

Co-Premiums

Building on the cost sharing structure of the 2008 CHPlus B expansion in New York State, CSS proposes to progressively stage individual and family co-premiums. Co-premiums increase as income increases—tracking (and, at higher incomes, surpassing) typical employee

³ Undocumented immigrant adults in New York State are currently not eligible for Family Health Plus. Lawful immigrants, including persons who are Permanently Residing Under Color of Law (PRUCOL) are eligible for Medicaid or Family Health Plus in New York State, depending on income level. Under this proposal, all immigrant adults will be eligible for Family Health Plus, regardless of immigration status.

co-premiums in employer-sponsored insurance (ESI). The co-premiums are based on available data on commercial insurance premium costs and research on health insurance affordability conducted by CSS and other researchers in the field.

The Cornerstone for Coverage proposal supplements the existing child maximum co-premium in CHPlus B with a family maximum co-premium. The proposed family maximum co-premiums represent the equivalent for a family of two adults and one child.

Existing and Proposed Child, Adult and Family Maximum Enrollee Co-Premiums				
Family Income Group	Maximum Monthly Income for a Family of Three	Per Child Monthly Premium	Per Adult Monthly Premium	Per Family Monthly Premium Maximum
<160% FPL	\$2,289	Free	Free	Free
160-222% FPL	\$3,191	\$9/child	\$18/adult	\$45
223-250% FPL	\$3,591	\$15/child	\$30/adult	\$75
251-300% FPL	\$4,307	\$25/child	\$50/adult	\$125
301-350% FPL	\$5,022	\$35/child	\$70/adult	\$175
351-400% FPL	\$5,738	\$50/child	\$100/adult	\$250
401-500% FPL	\$7,168	\$70/child	\$140/adult	\$350
501-600% FPL	\$8,599	\$100/child	\$200/adult	\$500
> 600% FPL*	> \$8,599	Full Premium Cost	Full Premium Cost	Full Premium Cost

* Individuals and families above this level may purchase coverage with no government subsidy.

The proposed individual and family co-premium levels range from 1.4% to roughly 7.0% of gross family income. In the chart below, we use the lowest family income level for each income group to calculate the highest possible percent of income attributed to co-premiums. Because the federal poverty level varies with family size, the family maximum co-premiums constitute a smaller share of family income as family size increases.

Premiums as Percent of Income by Family Size – Adults and Children							
Family Income Group	One Adult	One Adult and One Child	One Adult and Two Children	Two Adults	Two Adults and One Child	Two Adults and Two Children	Two Adults and Three Children
<160% FPL	Free	Free	Free	Free	Free	Free	Free
160-222% FPL	1.4%	1.5%	1.6%	2.0%	2.0%	1.7%	1.4%
223-250% FPL	1.6%	1.8%	1.9%	2.4%	2.4%	2.0%	1.7%
251-300% FPL	2.4%	2.7%	2.8%	3.6%	3.6%	3.0%	2.6%
301-350% FPL	2.8%	3.2%	3.3%	4.2%	4.2%	3.5%	3.0%
351-400% FPL	3.5%	3.9%	4.0%	5.2%	5.1%	4.3%	3.7%
401-500% FPL	4.3%	4.8%	4.9%	6.3%	6.3%	5.2%	4.5%
501-600% FPL	4.7%	5.2%	5.6%	7.0%	7.0%	5.8%	5.0%
> 600% FPL*	≤ 4.9%	≤ 5.5%	≤ 5.8%	≤ 7.4%	≤ 7.3%	≤ 6.1%	≤ 5.2%

* Assumes full premium cost at 2008 projected average statewide FHPlus and CHPlus B premiums, actuarially derived by Milliman Actuarial Associates.

Co-Payments

Currently, FHPlus requires no premiums or deductibles from enrollees. Most enrollees are subject to limited cost sharing requirements (co-payments) that vary by type of service, usually ranging from \$3 to \$25. The current co-payment structure in FHPlus would apply to new enrollees under the proposed FHPlus expansion.

Under Family Health Plus, the following people currently are exempt from making co-payments:

- People who state they cannot afford to pay. Health care providers have an obligation to provide services regardless of the patient's ability to pay co-payments.
- People under 21 years of age.
- Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- People obtaining reproductive health services, including prescription birth control.

These exemptions would remain in effect for individuals under 160% FPL and children under 21 years of age. However, adults with incomes over 160% FPL would not qualify for exemptions from modest co-payments.

Employer Buy-In

In June 2007, Governor Spitzer signed into law the Family Health Plus “Buy-In” program, which allows employers and union benefit funds to offer FHPlus coverage to their employees/members and their families, regardless of the employee’s income. Under this program, participating employers/unions are required to contribute a minimum of either 70% of the full premium or a fixed dollar amount, as determined by the Department of Health. The State, at its discretion, may subsidize the employer’s share for populations eligible for Medicaid, CHPlus B or FHPlus if either the employer did not offer coverage before or the employer coverage is in jeopardy. If an employee is eligible for public coverage, the State will pay the remaining premium; if not, the employees are required to pay the balance.

To maximize effective interaction between the buy-in program and the Cornerstone for Coverage, cost sharing among employers, the State and employees must be tailored to ensure that employers have incentive to participate, State costs are minimized, and employees’ cost sharing remains affordable.

With this in mind, the employer buy-in program is expanded under the Cornerstone for Coverage proposal so that employees pay the same (individual or family) co-premiums as they would if they enrolled in public coverage without their employer’s participation. When the employee share represents less than 30% of the total premium cost, employers would contribute a minimum of 70% of the total premium cost, with the State bearing any remaining costs. When

the employee share represents more than 30% of the total premium cost, employers would contribute the total remaining share, with the State bearing none of the cost. Employers would have the option of paying a larger share of their employees' premiums, which could decrease employee co-premiums below the co-premium levels in the individual FHPlus expansion.

Proposed Employer Buy-In Cost Sharing -- Single Adult					
Employee Family Income	Maximum Monthly Income for a Family of Three	FHPlus Premium – Average Total Monthly Cost*	FHPlus Monthly Enrollee Co-Premium, % of Total Premium	Employer Share of FHPlus Premium	Estimated State Share of FHPlus Premium
0-160% FPL	\$2,289	\$253.41	No Co-Premium	70%	30%
160-222% FPL	\$3,176	\$253.41	\$18 (7%)	70%	23%
223-250% FPL	\$3,577	\$253.41	\$30 (12%)	70%	18%
251-300% FPL	\$4,293	\$253.41	\$50 (20%)	70%	10%
301-350% FPL	\$5,008	\$253.41	\$70 (28%)	70%	2%
351-400% FPL	\$5,723	\$253.41	\$100 (40%)	60%	0%
401-500% FPL	\$7,154	\$253.41	\$140 (55%)	45%	0%
501-600% FPL	\$8,585	\$253.41	\$200 (79%)	21%	0%
>600% FPL	>\$8,585	\$253.41	Full premium	0%	0%

* Average FHPlus monthly premiums actuarially derived by Milliman Actuarial Associates. See details below.

Crowd-Out Limiting Features

Any health reform proposal will include significant numbers of people who were previously insured through the employers or through direct pay market (“crowd out” enrollees). Of the 1.8 million new enrollees, CSS conservatively estimates approximately half will have been previously insured. The Cornerstone for Coverage proposal address the concern includes two major crowd-out limiting features.

The first, a waiting period, builds on the CHPlus B and FHPlus programs' current crowd-out limiting features, and considers recent guidance provided by the federal government on crowd-out prevention among children enrolled in CHPlus B with income above 250% of FPL. If an individual becomes eligible for Family Health Plus or Child Health Plus under this expansion, chooses to enroll, and would be transitioning from private coverage, a waiting period will be administered for both children and adults (with some exemptions).

The second crowd-out limiting feature is enrollee cost sharing, which has been shown to substantially reduce crowd-out. The proposed Family Health Plus and Child Health Plus expansions include substantial cost sharing, as described above.

Waiting Periods

Currently, FHPlus imposes a waiting period of 9 months and CHPlus B imposes a waiting period of 6 months, but only after a finding that crowd out accounts for 8% of all new

enrollees.⁴ Under the expansion proposals, these rules would remain in place for all populations. In addition, consistent with the recent CHPlus B expansion, a six month waiting period will be imposed for those with private coverage before enrollment will be permitted in Family Health Plus or Child Health Plus for adults over 160% FPL and children over 250% FPL. This waiting period will be administered regardless of overall levels of crowd-out in the program.

Following the existing structure of the FHPlus and CHPlus B programs, the following groups would be exempt from all waiting periods:

- Those who have lost employer coverage involuntarily, through loss of job, death in the family, move to a job that does not offer coverage, expiration of COBRA benefits etc.;
- Those for whom employer coverage or COBRA costs are 5% or more of total income;
- Pregnant women of any age;
- Children under the age of five (subject to Federal approval).

Experience in other states indicates that 6 months is a reasonable waiting period. Of 35 states with waiting periods under SCHIP in 2006, 16 states had implemented waiting periods of six months, 11 states had waiting periods of three months and seven states had waiting periods of four or less months. Only one state had a waiting period longer than 6 months (12 months), and 16 states had no waiting periods at all.⁵

Recently, the Centers for Medicare and Medicaid Services (CMS) issued guidance indicating that states must establish a minimum of a one year period of uninsurance for individuals above 250% FPL prior to receiving coverage under the State Child Health Insurance Program (SCHIP or CHPlus B in New York).⁶ Several states (including New York) and a group of families (represented by CSS and other advocacy groups) have challenged this mandate in a number of court cases, and Congress is currently considering legislation that could overturn the guidance. Depending on the outcome of these events, the state may need to align the program's crowd-out-limiting features with this federal mandate to obtain federal SCHIP funds.

Cost Sharing

The Cornerstone's staged cost sharing, as outlined above, also will reduce crowd-out. By setting premium levels (for higher-income participants) near or above the private market average premium contributions in employer-sponsored insurance, there is little financial motivation for employee substitution from employer-sponsored coverage (when available) to public coverage under this proposal. This is particularly true for individuals and families above 300% FPL, when the proposed co-premium levels overtake average cost sharing in ESI.

⁴ To date, Family Health Plus has not reached an 8% crowd out level.

⁵ Lynn A. Blewett and Kathleen T. Call, *Revisiting Crowd-out*, The Synthesis Project, Robert Wood Johnson Foundation (September 2007) available at <http://www.rwjf.org/files/research/revisitingcrowdout.pdf>.

⁶ Centers for Medicare and Medicaid Services. Center for Medicaid and State Operations. Dear State Health Official Letter #07-001. August 17, 2007.

One of the measures used to support CSS’s premium structure was an analysis of medical costs and premiums in ESI derived from an analysis of the Medical Expenditure Panel Survey. Our analysis determined that most people (73%) people in our region pay less than seven percent (7%) of their family’s gross income on all health care expenditures.⁷

Cornerstone for Coverage: Proposed Co-Premiums Relative to ESI Co-Premiums				
Cornerstone for Coverage Proposed Co-Premiums as a Percent of Gross Family Income			Percent of ESI holders* for whom CSS Premiums are at or Above ESI Premiums	
Family Income Group	Per Adult Monthly Premium	Two Adults and One Child Monthly Premium Maximum	Single Adult	Family of Two Adults and One or More Children
<160% FPL	Free	Free	50%	50%
160-222% FPL	\$18 (1.3%)	\$45 (2.0%)	54%	36%
223-250% FPL	\$30 (1.6%)	\$75 (2.4%)	50%	50%
251-300% FPL	\$50 (2.4%)	\$125 (3.5%)	59%	70%
301-350% FPL	\$70 (2.7%)	\$175 (4.1%)	69%	84%
351-400% FPL	\$100 (3.4%)	\$250 (5.0%)	85%	96%
401-500% FPL	\$140 (4.1%)	\$350 (6.1%)	85%	95%
501-600% FPL	\$200 (4.7%)	\$500 (7.0%)	97%	95%
> 600% FPL	\$253 (≤4.9%)	\$632 (≤7.3%)	96%	99%

* Data represents families with at least one working adult where one or more family members hold ESI coverage from a current employer. Methodological detail on CSS’s MEPS analysis available upon request.

As described in detail in the affordability discussion in the Appendix below, CSS extensively field tested these premiums through a statewide poll of New Yorkers. The results from this survey revealed that these premium schedule, displayed above, were well received by the majority of those sampled.

C. Costs and Financing

The Cornerstone for Coverage offers a practical, achievable and cost-effective universal health coverage option for New York State. While CSS has not yet fully developed a financing plan for the Cornerstone proposal, by leveraging the availability of federal matching funds, New York State could bear as little as \$2.8 billion of the total program costs associated with the Cornerstone for Coverage in the fifth year following implementation of the program. In fact, with full federal matching funds, New York could finance this program from the existing HCRA pools (including a portion of the GHI and HIP conversion funds), thereby obviating the need for any commitment of general revenue funds for at least a decade. CSS will develop a comprehensive financing proposal over the next few months.

⁷ Sixty-one percent of the people in our region pay five percent or less of their income on

Even without matching funds, the Cornerstone for Coverage would be less expensive for New York State than any other universal coverage program which has been proposed. Due to ability to harness the full buying power of the State, offsets from family and employer cost sharing, these costs represent a highly cost-effective strategy for addressing the needs of our State's uninsured.

Cornerstone for Coverage: Monthly Government Cost per Enrollee				
	Total New Enrollees - Previously Uninsured	Total New Enrollees	Total Government Cost (millions)	Average Monthly Total Government Cost per New Enrollee
Adults	855,330	1,736,824	\$4,428.5	\$212.48
Children	32,588	65,175	\$37.2	\$47.59
Total	887,918	1,801,999	\$4,465.7	\$206.52

D. Additional Cornerstone for Coverage Work under Development

1. Reduction of Racial Disparities Initiative

In April 2008, CSS received a generous grant from the New York State Health Foundation to develop a racial initiative that could serve either as a component to the Cornerstone for Coverage proposal, or could be used for the four million New Yorkers who are currently served by public insurance.

While still in development, this initiative will integrate the numerous current New York State initiatives targeting people of color through managed care and other insurance products. Possible features will include: (1) the design a set of statewide benchmarks of care through a stakeholder consensus process; (2) improvement and enhancement New York State Department of Health and managed care plan data collection and reduction of disparities performance measures; and (3) the development of a financial incentive systems (sometimes known as pay for performance) and a set of pools to reward those plans that either reduce racial disparities in health outcomes or develop innovative systems for reducing racial disparities in health care.

2. Additional Implementation Issues

CSS continues to seek to improve our Cornerstone for Coverage proposal. Additional areas of work include:

- **Actuarial Analysis of Adverse Selection.** A number of government officials and key stakeholders have raised the concern that the Cornerstone program is particularly vulnerable to adverse selection. While CSS does not believe that the Cornerstone for Coverage proposal is more vulnerable to adverse selection than any other proposal (short of a single-payer), CSS intends to work more with Milliman, the actuarial firm, to determine an actuarially sound analysis of the

impact of adverse selection on the Cornerstone's costs. This process may result in the revisiting of our take-up and crowd-out assumptions, especially in light of new research data from the Massachusetts experience.

- **Development of Financing Plan.** CSS will work to further identify a comprehensive financing plan for the Cornerstone for Coverage proposal, including: identifying potential sources and amounts of funding to underwrite the anticipated State costs of the Cornerstone for Coverage proposal (approximately \$2.6-\$4 billion with full implementation); legal or regulatory issues related to use of the funds; and policy considerations related to their use for the purposes of expanding access to health insurance coverage. Potential *Cornerstone for Coverage* financing sources include: federal financing, the HIP/GHI conversion, Health Care Reform Act (HCRA) (including the Bad Debt and Charity Care pool) or a tobacco tax. Based on the findings, CSS will outline a financing plan for the Cornerstone for Coverage proposal.
- **Development of a Ten-Year Plan.** The Cornerstone for Coverage proposal has been crafted as a significant and achievable first step towards universal coverage in New York State. In response to many requests from various stakeholders, CSS intends to outline the transition of the Cornerstone proposal to full universal coverage in New York State over a ten-year period. The plan will address when and if health insurance mandates should be implemented in the state.

Conclusion

The Cornerstone for Coverage proposal offers an achievable implementation pathway to universal coverage in New York State by making affordable, comprehensive coverage immediately available to every New Yorker. The proposal reflects thoughtful consideration of the best available research and experience on the topic of insurance coverage reform, as well as findings from CSS's original polling of New Yorkers.

Thank you for your interest in the Cornerstone for Coverage proposal. For more information about the Cornerstone for Coverage proposal, please contact Elisabeth Benjamin, Director of Healthcare Restructuring Initiatives, Community Service Society, at: 212-614-5461.

Appendix: Methodological Considerations (as of May 7, 2008)⁸

In crafting the Universal Health Access Proposal outlined above, CSS has been committed to engaging in a rigorous review of the available data and literature, and to ensuring that our findings and assumptions reflect this research. This process has revealed considerable variation in the literature regarding methodological choices and assumptions that are core to modeling any universal coverage approach. In order to both reach the most accurate result and to engender public faith and trust in that result, it is vital that these methodological choices and assumptions be transparent and informed by people who are knowledgeable about considerations specific to New York.

It is crucial that methodological decisions regarding key issues, such as affordability standards, take-up and crowd-out, and other program features of health coverage in New York, are subject to open and vigorous discussion and we believe that our research in these areas can add value to these discussions. As such, the following section outlines CSS's approach to the following methodological issues:

- Affordability
- Take-Up and Crowd-Out
- Premium Cost Modeling
- Employer Buy-In Modeling
- Impact and Efficacy of Mandates

A. Affordability

Affordability is the most central consideration in the design of New York's health insurance coverage initiative. While few would argue that universal coverage requires that health insurance be affordable, how best to define affordability and set affordability standards has been a point of considerable debate at the State and national level in recent months. Ultimately, determining what is affordable requires both an understanding of the available data and academic research, and an understanding of New York-specific values and realities.

There is significant debate in the academic literature on the issue of affordability, some of which has grown out of the necessity to define affordability pursuant to implementation of coverage mandates in Massachusetts. Researchers have used a variety of methodologies and datasets in their attempts to measure and define affordability, ranging from observation of what families actually pay for health insurance in the private market, through examinations of family budgeting and self-sufficiency standards, to economic modeling.

Affordability Experience in Massachusetts

⁸ Over the next few months, CSS will incorporate new information and research and will produce a refined document that describes our analysis, methodology and findings document.

In the case of Massachusetts, the large number of exemptions from the coverage mandate on affordability grounds indicates that the adopted standards of affordability are unrealistically high. For example, as many as 60,000 Massachusetts residents may be exempted (approximately 20% of the state's uninsured population) from complying with the state's individual coverage mandate due to their inability to afford available coverage options.⁹

The enrollment in Massachusetts' Commonwealth Choice plans also indicates that the state's affordability standards were unrealistic. As of November 2007, the vast majority of people who had enrolled since the universal health coverage mandate was implemented had enrolled in fully subsidized plans. The rate of enrollment of the uninsured in subsidized plans also decreased sharply at higher income levels. Nearly 90% of the uninsured below 100% FPL had enrolled; 81% between 100-200% FPL, and only 29% of the uninsured between 200-300% FPL. The significantly lower rate of enrollment in subsidized plans with higher premiums (i.e., plans for individuals earning 200-300% FPL) strongly indicates that the premiums for these plans are unaffordable.

Enrollment in Commonwealth Choice plans (unsubsidized coverage for people earning above 300% FPL) has been even more sluggish. The Massachusetts program considers premiums that range between 6%-10% of gross family income to be affordable.

However, it appears that the several hundred thousand uninsured residents disagree with the State's affordability standards. As of early January 2008, only 15,938 people had enrolled in the unsubsidized plans (12,420 subscribers and 3,518 dependents). Of these members, almost half (44%) have chosen the lowest premium option, the Bronze tier plan, and an additional 29% are enrolled in Young Adult Plans, available to adults age 19-26, which are similar to Bronze plans but with annual maximums. Only 20% of subscribers are enrolled in the Silver plan (2,440 subscribers) and only 7% are enrolled in the Gold Plan (867 subscribers), which has the most expensive premiums and the most comprehensive benefits. In addition, it is worth noting that roughly one-third of enrollees chose plans without pharmacy coverage.¹⁰

Polling Data on Affordability in New York State

CSS has approached the question of affordability through a series of inquiries: (1) a MEPS analysis; (2) a convenience sample of 258 New York families; and (3) through polling. Our MEPS analysis and convenience sample results previously have been presented to the State.

In November 2007, working with the nationally-recognized polling firm, Lake Research Associates, CSS interviewed 1,619 New York State residents in four regions of New York: New

⁹ Dembner, Alice. "Health Plan May Exempt 20% of Uninsured." *Boston Globe*. April 12, 2007. http://www.boston.com/news/local/massachusetts/articles/2007/04/12/health_plan_may_exempt_20_of_the_uninsured

¹⁰ Barber, Christine, and Michael Miller. "Revisiting Massachusetts Health Reform: 18 Months Later." Community Catalyst. December 2007. Available at: http://www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf

York City, Long Island, Rural Upstate and Urban Upstate communities. The margins of error are +/- 2.5% for our statewide results and +/- 4.9% for our regional results.

In the poll, we approached the issue of affordability and pricing from four directions. First, we found that a majority (57%) of New Yorkers at every income level said that paying about 5% of their before-tax income on health care was about right; 27% of New Yorkers thought 5% was too much and only 9% of New Yorkers thought 5% was too little. Respondents with children were much more cost sensitive on this question, with 36% of parents saying that spending 5% of their pre-tax income was too much.

We then asked New Yorkers how much they could afford to spend on health coverage and how much they currently spend on health coverage. We found that, on average, New Yorkers said that they could afford to spend around \$190 per month on health insurance coverage, and that they were currently spending around \$163 per month on health coverage.

Next we asked a series of pricing questions, geared to the sample at three different income levels: below 200% of FPL; between 200%-400% of FPL; and above 400% of FPL. We found:

- 80% of people below 200% of FPL favor charging families making around \$34,000 a year \$45 per month for health insurance;
- 77% of people between 200%-400% of FPL favor charging families making around \$52,000 around \$125 per month for health insurance; and
- 58% of families above 400% of FPL favor charging families making around \$69,000 around \$350 per month for health insurance.

Support for these price points at all three income levels was strongest in rural upstate New York.

Finally, we asked people to consider these price points (or similar price points depending on their household composition) thinking about their own income or their families' income. We found that support remained strong for these pricing points for individuals and families up to 400% of FPL, but that support dropped for families above 400% of FPL.

- More than half of residents below 200% of FPL say that they are extremely willing to pay either \$18 per month for a single or \$45 per month for a family for health insurance (71% were either very willing or extremely willing to do so);
- Three in four (75%) of single people were very or extremely willing to pay \$18 per month at incomes below 200% of FPL; \$30 per month at income between 200%-400% of FPL and \$70 per month at incomes above 400% of FPL for health insurance coverage.

Support for the price points held for families, with the exception of families over 400% of FPL who expressed skepticism at being asked to pay \$350 per month for family coverage (24% not at all willing, 52% somewhat willing or less).

Methodological Issues in Setting Affordability Standards

There are several methodological decisions, common in the literature, which may have contributed to the problematic initial outcome of the affordability standards associated with the Massachusetts' health care reforms, and which CSS believes can be avoided in setting reasonable affordability standards under a universal coverage program in New York State.

First, in many cases, researchers have sought to apply affordability standards benchmarked to the non-group market, or even the full cost of employer-sponsored insurance (accounting for the tax benefits), on the logic that these are the actual costs of coverage, and are borne by employees in the form of lower wages. However, this methodological decision could be considered to yield results which are not applicable or realistic when applied to the experience of the majority of uninsured individuals and families.

Costs in the non-group market are not a legitimate standard for the population overall, since individuals who choose to purchase non-group coverage usually do so because they have high need for health care, and their premiums are subject to costs which reflect this adverse selection effect.

In terms of the employer sponsored insurance (ESI) market, while there are certainly economic arguments to the contrary, there is a strong argument to be made that the actual cost of health care borne by enrollees (premiums plus out-of-pocket costs) is the appropriate benchmark for an affordability standard, rather than the full cost of ESI. While there may be some long-run trade-off between wages and employer share of the cost of health insurance coverage in ESI, the effect of this trade-off would be neither immediate nor direct. As our polling results indicate, the direct impact of premium cost levels on individuals and families, rather than generalized economic theory, will drive individual decisions regarding participation in the immediate term, as well as impacting political support for any reform. This should be a key consideration for policy-makers when considering an affordability standard.

Second, household budgeting and self-sufficiency standards have been a significant point of debate in the literature. While some researchers have found that most low- and moderate-income families have little to no resources to contribute to health insurance coverage,¹¹ others have developed methodologies which challenge this result. Some have chosen to ignore household income data, particularly for low-income households, on the theory that household income is often under-reported. Some researchers using the framework of self-sufficiency standards and available resources construct family necessities quite narrowly, or have suggested

¹¹ See, for example, the Economic Policy Institute's Budget Calculator at http://www.epi.org/content.cfm/datazone_fambud_budget

that requiring families to spend all available resources on health care constitute a legitimate affordability standard.¹²

As a methodological question, these strategies often yield results which paint a fairly rosy picture of the economic circumstances of low- and moderate-income families. This choice can have disastrous repercussions for modeling affordability.

Ultimately, reliable, household-based (not aggregate or median) data on income, expenses and health care spending can help inform any affordability modeling exercise. However, it is essential that this data be used with the understanding that it is highly susceptible to values-based underlying assumptions that heavily influence its result. What is a necessity in the family budget and what proportion of non-necessities should families be expected to dedicate to health coverage? Views on these questions vary considerably in the literature as in the electorate, and care should be taken to ensure that the methodological approach is transparent and reflective of New Yorkers' values and experiences.

B. Take-Up and Crowd-Out

As a purely methodological question, estimating take-up and crowd-out for a universal health coverage expansion – particularly an expansion that includes progressive co-premiums – is one of the most important and complex components of modeling such a program. How best to estimate who and how many uninsured individuals will take-up coverage, and how best to project the potential for crowd-out of coverage expansion proposals is an area of intense interest, but little reliable data or experience exists to illuminate the question, particularly for populations beyond 200% of the federal poverty level.

Thus far, CSS has used a flat take-up measure, which does not account for differences by income and does not reflect the impact of the proposed co-premiums relative to the elasticity of demand for coverage among the uninsured.¹³ This take-up measure could then be considered quite conservative, in that it yields a take-up estimate which is equivalent to expected take-up in an environment without cost sharing. Because the Cornerstone for Coverage proposal includes progressive cost sharing with costs near or above typical co-premium levels in the ESI market, in a more intensive modeling exercise it would certainly be legitimate to develop a take-up curve among the uninsured tied to co-premium costs at each family income level.

CSS's crowd-out estimates include relatively deep crowd-out assumptions that increase as income rises. Generally, researchers have found that the likelihood of crowd-out increases as income increases, largely because the probability of having employer-sponsored insurance rises

¹² See, for example, Jonathan Gruber (2007), "Evidence on Affordability From Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance"

¹³ The United Hospital Fund, in its "Blueprint for Universal Health Insurance Coverage In New York" (Holahan, Hubert and Schoen, 2006) utilized this elasticity-based methodology.

with income.¹⁴ However, while crowd-out increases with increasing income, the likelihood of an individual choosing to substitute public insurance for private coverage may be offset as income increases, due to crowd-out limiting features (such as cost sharing) which effect higher-income enrollees more heavily, as well as the interaction of factors such as administrative burden and stigma with the fact that higher income individuals and families have lower price elasticity of demand in general.

These crowd-out assumptions, drawn from a review of the literature on the subject, do not distinguish employer crowd-out from employee crowd-out. However, research examining employer crowd-out has found little evidence of employer crowd-out associated with expanding access to public insurance for adults or children. When found, employer crowd-out related mostly to offers of dependent coverage in firms employing a large proportion of low-income workers.¹⁵ No evidence was found that employers reduce their premium contribution upon public health insurance expansion for which their employees may be eligible.¹⁶ Thus, it is likely that the bulk of crowd-out in public health insurance expansions is attributable to individuals choosing to substitute public coverage for existing private coverage, rather than employers choosing to no longer offer coverage based on the availability of public coverage for workers.

Reasonable people may disagree with the need for crowd-out assumptions as deep as those used in CSS's estimations, especially given the significant progressive cost-sharing proposed as part of the Cornerstone for Coverage. Indeed, it appears that these estimates may be significantly too conservative. Additional research has shown that virtually all individuals and families above 300% FPL who currently hold ESI are paying less for their ESI coverage than they would pay under the co-premiums proposed by CSS, for example. Individuals with other forms of private coverage (such as non-group insurance) tend to have higher premium costs, and thus would be more likely to transition from private insurance to public sponsored coverage, as public sponsored coverage would be significantly less expensive.

Lastly, it is important to note that there are significant barriers associated with take-up of publicly-sponsored coverage, including cumbersome enrollment requirements, stigma, and the potentially significant impact of changes in provider panels, which would particularly impact individuals with significant morbidities and high utilization (like many of those in the non-group market). These could also serve to depress crowd-out, particularly among individuals with higher incomes who have lower price elasticity of demand in general.

C. Premium Cost Modeling

¹⁴ Glied, S, Remler, DK, and Zivin, JG. Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals. *The Milbank Quarterly*, Vol. 80, No. 4. 2002.

¹⁵ Davidson, G, Blewett, LA, and Thiede Call, K. "Public program crowd-out of private coverage: What are the issues?" Robert Wood Johnson Foundation. June 2004.

¹⁶ Shore-Sheppard, L, Buchmueller, TC, and Jensen, GA. "Medicaid and crowding out of private insurance: a re-examination using firm level data." *Journal of Health Economics*. 19 (2000). 61-91.

The process of developing actuarially sound premium costs for a universal coverage expansion, assuming that such an expansion uses a managed care model, is central to any effort to model the costs of such an initiative. As part of the process of estimating the cost and enrollment levels associated with the Cornerstone for Coverage proposal, CSS worked with Milliman Actuarial Associates to develop actuarially-derived FHPlus premiums associated with the Cornerstone for Coverage. Using statewide Medicaid Managed Care Operating Report (MMCOR) data, Milliman calculated premiums for adults and children, taking into account demographic differences, and differences in morbidity and utilization, between current enrollees and the population of projected new eligibles. Milliman has calculated average 2008 FHPlus and CHPlus B premiums under the expansion, and proposes a 5% yearly increase per year. Milliman's full analysis is available upon request.

D. Employer Buy-In Modeling

Any public coverage expansion in New York State must account for the recently-enacted Family Health Plus Buy-In for employers and unions. Estimating take-up among employers and employees and crowd-out (particularly employer crowd-out) associated with this program component proved extremely difficult for CSS, due to lack of publicly available individual or firm-level employer-employee linked health insurance data, such as the MEPS/IC or Kaiser/HRET survey of employers.

After conducting a detailed review of the literature on the determinants of employer health insurance offers and employee take-up and speaking with experts in the field, including Don Gorman of Gorman Actuarial and Sherry Glied of the Mailman School of Public Health at Columbia, CSS determined that the Employer Buy-In would not significantly increase overall take-up, and would represent a small proportion of program participation. The primary benefit to employers of participating in the buy-in program would be the potential to leverage the group purchasing power of the State to obtain a rich benefit package for their employees at a relatively low price. However, the buy-in option would require employer contributions for populations, particularly those with low and moderate incomes, that could otherwise participate individually without such a contribution. Detailed information on this methodology is available upon request.

E. Impact and Efficacy of Mandates

Universal coverage expansion proposals for New York State must address the question of mandates. Mandates may have a valid policy goal (ensuring that all citizens have health insurance coverage), as well as potentially decreasing adverse selection and its attendant cost effects. However, health insurance mandates are largely untested, and should not be implemented precipitously.

Implementation of mandates also brings a significant risk that low- and moderate-income individuals and families could be penalized for not holding health insurance coverage, especially in a system where coverage may not be realistically affordable. Furthermore, the imposition of

mandates in an unaffordable system may build anti-government sentiment that could seriously undermine legitimate health reform efforts.

Individual mandates, unlike employer mandates are unpopular with the public. Indeed, CSS/Lake Research Associates polling data indicates strong opposition to mandates – especially in Upstate where more than a third of those polled strongly oppose the imposition of individual mandates to purchase health insurance. Mandates are similar unpopular with middle class New Yorkers above 200% of the federal poverty line.

Finally, the Massachusetts experience provides direct evidence that mandates may not in fact lead to universal coverage. Massachusetts expects to exempt 60,000 people (20% of the state's uninsured) on the basis of affordability.¹⁷ In addition, while over 200,000 uninsured have gained coverage in Massachusetts since implementation of the health care reform law, enforcement of the individual mandate only truly began at the end of 2007,¹⁸ and it is expected that a significant number of the uninsured may forgo coverage and be forced to pay penalties.¹⁹

¹⁷ Dembner (2007)

¹⁸ Barber and Miller (2007)

¹⁹ Felland, Laurie, Debra Draper and Allison Liebhaber. "Massachusetts Health Reform: Employers, Lower-Wage Workers and Universal Coverage." Center for Studying Health System Change. July 2007. Available at: <http://www.hschnge.com/CONTENT/939/>