

A Blueprint for Universal Health Insurance Coverage in New York



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Executive Summary

This report presents the *Blueprint for Coverage in New York*, a project undertaken by the United Hospital Fund and The Commonwealth Fund to explore options for achieving universal health insurance coverage in New York. We developed approaches that would address the specific characteristics of New York’s 2.8 million uninsured and establish a more secure foundation of coverage for all New Yorkers. We explored a combination of voluntary public program reforms, premium subsidies to make coverage more affordable, a new group insurance purchasing mechanism, and employer and individual mandates to reach these goals. While these changes could be made individually, when implemented together they would achieve universal coverage and improve coverage options for the insured to provide a more stable health insurance system for all New Yorkers. We present the estimated costs and coverage impacts of these expansion scenarios as prepared by The Lewin Group using its Health Benefits Simulation Model.

Our approach is designed to be implemented as a series of “building blocks” with which reforms would first be made to public programs, to increase participation rates and make affordable coverage available to a greater share of low- and moderate-income persons. Specifically, we would simplify public program rules to enroll those who are currently eligible but uninsured, expand Family Health Plus (FHP) eligibility for childless adults, and allow low-to-moderate-income New Yorkers to “buy in” to FHP with income-related premium assistance. With the introduction of the buy-in, New York would implement a new statewide purchasing mechanism—an “Insurance Exchange”—that would provide individuals with a choice of additional coverage options at group rates. These changes would lay the foundation for other reforms.

The following policy changes were modeled:

- **Public Programs.** Simplification and expansion of existing public programs with three components:
 - Simplification of public program rules to ease enrollment and renewal in order to increase participation rates among eligible but uninsured persons;
 - Expansion of Family Health Plus eligibility for childless adults to 150 percent of the federal poverty level (FPL);
 - Subsidized buy-in to FHP so that affordable coverage is available to more moderate-income New Yorkers (up to 300 percent FPL);
- **Insurance Exchange.** Implementation of a new purchasing entity for individual purchase of coverage at pooled group rates;
- **Employer Requirements.** Two variations of assessments on employers with 10 or more employees that do not offer health insurance:
 - A modest employer assessment of \$400 per worker per year;
 - An employer “pay-or-play” assessment of 8 percent of payroll or a credit toward this assessment for coverage offered (on average, the assessment would be \$3,200 per worker);
- **Individual Mandate.** A requirement that all residents purchase health insurance coverage, with income-related premium assistance.

SUMMARY OF FINDINGS The modeling results indicate that implementing the simplification, FHP expansion, and FHP buy-in together (“combined public program changes”) would achieve only a one-third reduction in the uninsured, and leave two million uninsured New Yorkers. In addition, the availability of

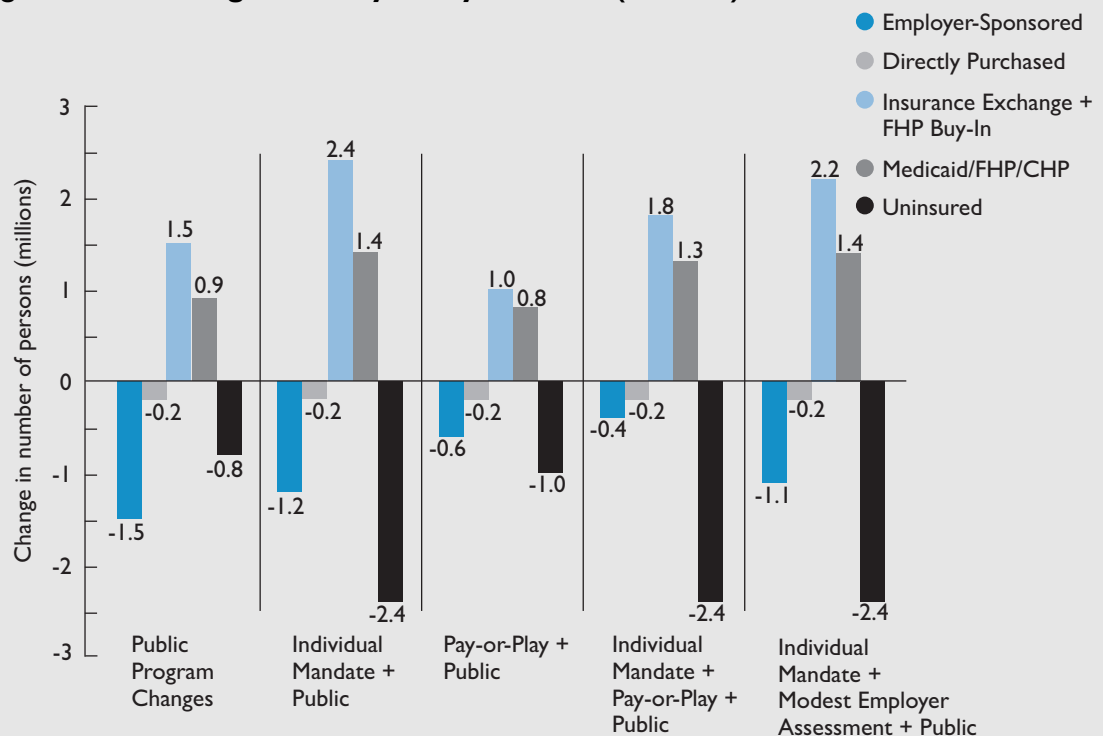
subsidized coverage through the FHP buy-in would improve the affordability of coverage for currently insured low-to-moderate-income individuals and families, compared with what is currently available through employer-sponsored insurance (ESI) and non-group insurance. As a result, there would be a significant shift from ESI and non-group insurance into this new coverage option. We therefore explored mandatory coverage scenarios, including requirements for employers to offer coverage, contribute financially toward the cost of coverage, or both—as well as mandates on individuals to purchase coverage. Ultimately, an individual mandate is required to achieve universal coverage (see Figure ES-1).

The costs of such reforms are borne by government, employers, and families and are distributed differently depending upon the specific approach. Scenarios that do not include any employer requirements would result in

significant shifts out of employer-sponsored coverage into new subsidized options available through the Insurance Exchange, without any new sources of financing for this shift. This would place the burden of new spending on the state and families, and ultimately result in significant net savings to employers (see Figure ES-2).*

As this analysis makes clear, only policy options with individual mandates achieve the goal of universal coverage. Among these options, those that require some shared responsibility from employers achieve greater equity among employers, limit erosion of employer coverage, and reduce state fiscal responsibility. Two options, therefore, bear special scrutiny: 1) the combination of public program expansions, individual mandate, and a modest employer assessment, and 2) the combination of public program expansions, individual mandate, and employer pay-or-play.

Figure ES-1. Coverage Shifts by Policy Scenario (millions)



Note: Coverage shifts for Pay-or-Play, Individual Mandate, Pay-or-Play with Individual Mandate, and Modest Employer Assessment with Individual Mandate scenarios include coverage shifts for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and FHP buy-in).

Numbers presented in this chart may not sum to totals and may not match numbers in the text due to rounding.

*Note that—while not shown here—the modeling assumes that, over time, savings to employers would be passed back to workers in the form of wage increases. However, the cost estimates presented here do not include the wage effects associated with these policy changes. (See Appendix B in the full report for a discussion of The Lewin Group modeling assumptions.)

UNIVERSAL COVERAGE: INDIVIDUAL MANDATE AND MODEST EMPLOYER

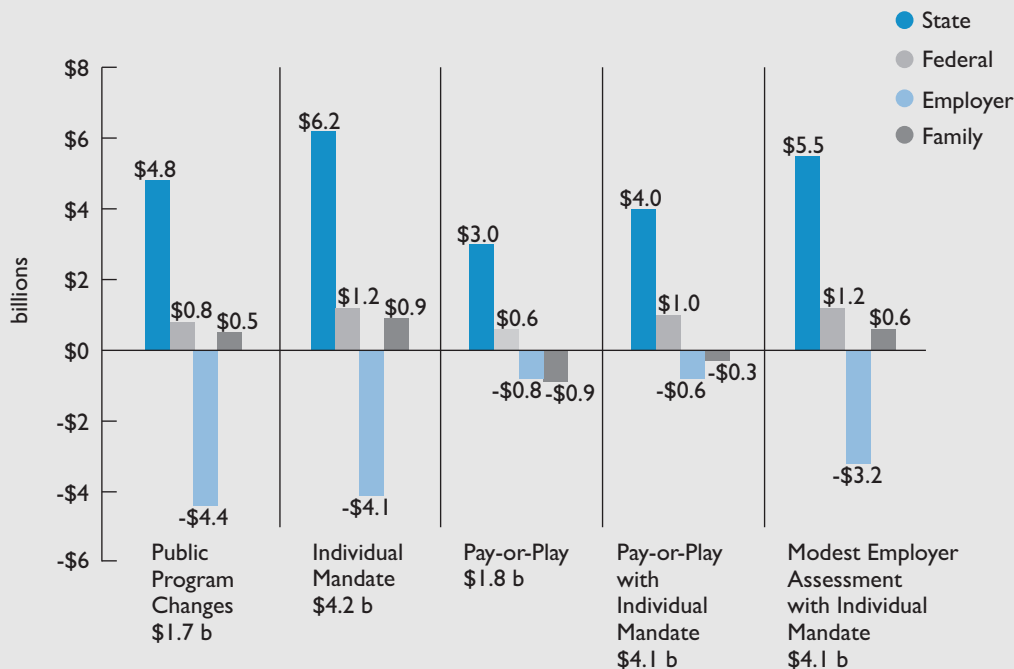
ASSESSMENT This option for universal coverage is modeled closely on the 2006 Massachusetts Health Reform law. This policy scenario includes public program reforms (as described above), a modest assessment on employers of \$400 per worker for firms with more than 10 workers, and an individual mandate. Our modeling results indicate that this combination of policy reforms would:

- Cover 2.4 million uninsured New Yorkers, achieving a 98 percent coverage rate (see Figure ES-3).
 - The individual mandate would compel a significant increase in take-up of available public and employer-sponsored coverage, driving the reduction in the number of uninsured.
 - The employer assessment, because it is small, would not provide an incentive for many employers to newly offer coverage,

and so there would be no direct impact on coverage rates from the assessment itself;

- Result in a shift of people from employer and non-group coverage into public programs and the Exchange, due to the availability of subsidized coverage;
- Raise \$400 million in revenues to offset the state’s cost of the coverage expansions;
- Result in a net cost of \$4.1 billion (see Figure ES-4). This includes, by payer:
 - New York State. Increased spending of \$5.5 billion, mostly for subsidies in the Exchange;
 - Federal government. Increased spending of \$1.2 billion in matching payments for currently eligible public program enrollees;
 - Families. Increased spending of \$600 million because of premium requirements in the Exchange; and
 - Employers. Savings of \$3.2 billion because some employers currently

Figure ES-2. Net Change in Spending by Payer* (billions)



Note: Costs for Pay-or-Play, Pay-or-Play with Individual Mandate, Individual Mandate, and Modest Employer Assessment with Individual Mandate scenarios also include costs for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and FHP buy-in).

* Reflects change over current spending on health insurance.

offering coverage would drop it with the availability of subsidized coverage in the Exchange.

- Currently insuring employers would save \$3.6 billion;
- Currently non-insuring employers would spend \$400 million more than under current law.

UNIVERSAL COVERAGE: INDIVIDUAL MANDATE AND EMPLOYER PAY-OR-PLAY

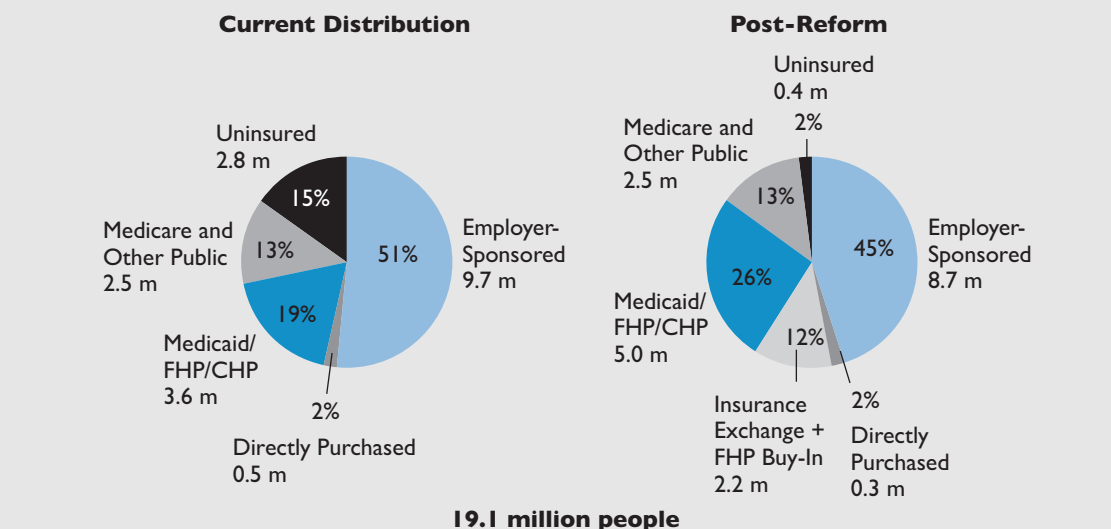
This universal coverage option is modeled on a “Creating Consensus” proposal that shares responsibility among employers, as well as with federal and state governments and individuals. In addition to public program expansions for low-income individuals, it includes both an individual mandate and an employer pay-or-play contribution. The employer pay-or-play policy assessment (8 percent payroll assessment on firms with more than 10 workers) is comparable to the typical contribution toward an individual premium by employers that finance health benefits for employees. It would

encourage a greater number of employers to continue to offer coverage directly than the more modest assessment, and would provide a source of financing to support the cost of other reforms.

The policy would reduce the number of uninsured by 2.4 million, as would the modest employer assessment combined with public program expansion and the individual mandate. However, it would reduce state outlays from \$5.5 billion under the modest employer assessment to \$4 billion under the employer pay-or-play option. Employers would save \$600 million overall relative to the current system of financing. Currently insuring employers’ costs would decrease by \$1.7 billion because some would drop coverage and pay the assessment as a result of low-wage worker subsidies, while employers that do not currently finance coverage would see an increase in spending of \$1.1 billion on newly offered coverage or assessments. Families would save \$300 million compared with current law.

A key issue in making universal coverage

Figure ES-3. Distribution of Health Insurance Coverage, Before and After Reform (Public Expansion, Insurance Exchange, Individual Mandate, and Modest Employer Assessment)



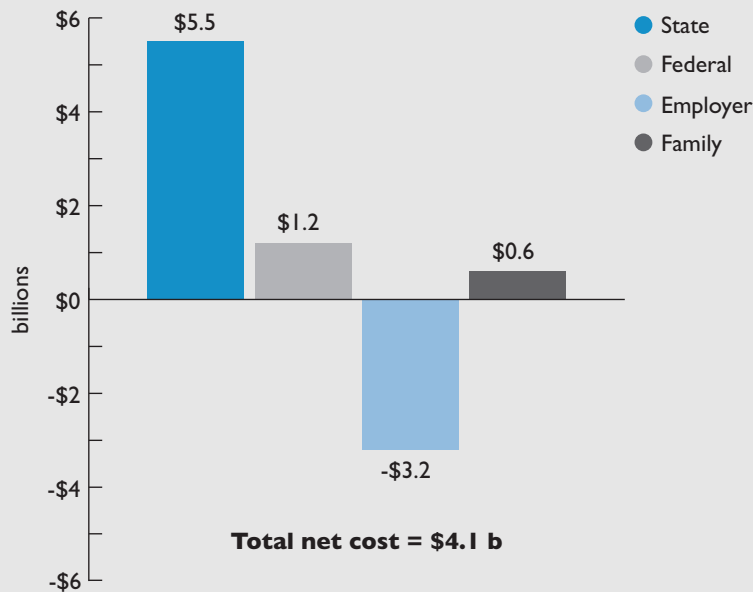
Note: “Post-Reform” scenario includes administrative simplification, expansion of FHP to 150% FPL, subsidized buy-in to FHP (150%-300% FPL), individual mandate, and modest employer assessment. “Medicare and Other Public” category includes dual eligibles and persons covered by CHAMPUS. Data include persons of all ages. Numbers may not sum to 100% due to rounding.

work is whether or not New York has sufficient money to finance it. Financing options include redirecting uncompensated care subsidy funds (an estimated \$1.3 billion in state and local payments), tapping employers for contributions, seeking federal financial participation for the FHP expansion and buy-in, and raising the residual funds required.

Ultimately, universal coverage would eliminate the most significant source of inequity and inefficiency from the health care system and would provide a foundation for making large-scale improvements. Coverage would allow formerly uninsured persons to access services more easily and receive timely

and appropriate care. Providers would be reimbursed directly rather than through indirect subsidies, and linking payments to people would allow for a greater level of accountability in the system. Further, significant enrollment in the Exchange could make it a vehicle for driving cost control and quality reforms. Once all persons are covered, the state can approach system change to achieve the most comprehensive and effective solutions to the enduring challenges of the quality and cost of care. Universal coverage is a significant achievement in its own right. It is also a fundamental step toward realizing a high-performance health care system.

Figure ES-4. Net Change in Spending by Payer: Modest Employer Assessment with Individual Mandate and All Public Program Changes (billions)



Part I. Background and Strategies

Introduction

This report presents the *Blueprint for Coverage in New York*, a project undertaken by the United Hospital Fund and The Commonwealth Fund to explore a set of strategies to achieve universal health insurance coverage in New York.¹ Taking into consideration the characteristics of New York's uninsured, as well as problems with existing public and private coverage, we developed specifications for a series of detailed coverage expansion options that would not only expand coverage for the uninsured but also establish a more secure foundation of coverage for all New Yorkers. We explored a series of voluntary public program reforms, premium subsidies to make coverage more affordable, a new group insurance purchasing mechanism, and employer and individual mandates to reach these goals. While these changes could be made individually, when implemented together they would achieve universal coverage and improve other coverage options for the insured to provide a more cohesive and stable health insurance system for New York.

In this report, we present the findings of simulation modeling of these expansion scenarios conducted by The Lewin Group using its Health Benefits Simulation Model (HBSM).² We report the estimated costs and coverage impacts of a range of policies to expand health insurance coverage in New York.

Health Insurance Coverage in New York: The Current Picture

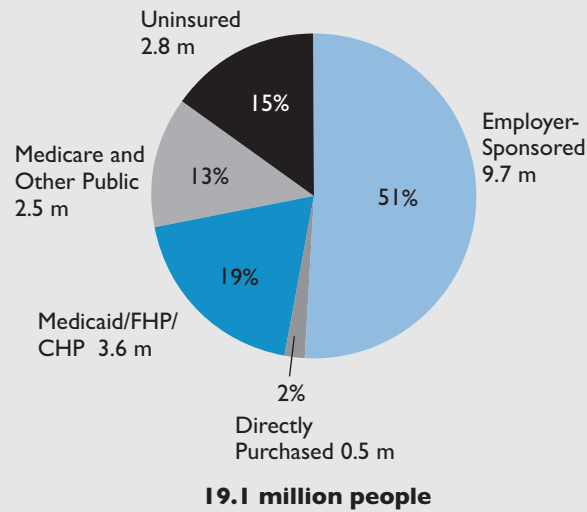
More than 9.7 million New Yorkers of all ages, or just over half of the state's population, are covered by employer-sponsored insurance, while only two percent of New York State residents purchase coverage directly through the non-group market. One-fifth of New

Yorkers, or 3.6 million people, are covered by a public health insurance program such as Medicaid, Family Health Plus (FHP), or Child Health Plus (CHP).³ For non-disabled adults and children, most of this publicly sponsored coverage is provided by private plans contracting with New York's public programs. Another 13 percent of the state's residents are covered by Medicare or other public coverage, such as CHAMPUS. Finally, about 2.8 million residents of all ages are uninsured, representing 15 percent of the State's total population (see Figure 1).⁴

Coverage within these categories is not static, however—people move in and out of different categories as well as lose and gain insurance. Even for individuals and families who have health insurance, coverage is often unstable, uncertain, or increasingly unaffordable. In the employer-sponsored insurance market, premiums have been rising, forcing many employers to require higher premium contributions and cost-sharing from their workers. As coverage becomes less affordable, employer-sponsored coverage has been gradually eroding.⁵ Premiums in the non-group or direct-pay market are largely unaffordable for low-to-moderate-income New Yorkers, and have also been rising in recent years.⁶ In addition, the problem of churning among public program beneficiaries—cycling on and off coverage despite continued eligibility—is well documented.⁷ Together, the coverage expansion approaches presented in the *Blueprint for Coverage* would help to address these issues and stabilize coverage for all New Yorkers.

New York's policymakers have taken a bipartisan approach to expanding health insurance coverage, drawing on strategies that include public health insurance expansions for children through Child Health Plus and for

Figure 1. Distribution of Health Insurance Coverage in New York State, 2006



Source: Lewin Group estimates, based on 2005 Current Population Survey data trended forward to 2006.
Note: Data include persons of all ages. Numbers may not sum to 100% due to rounding.

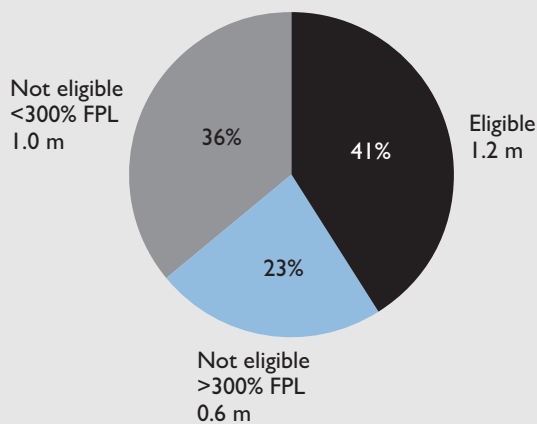
parents and childless adults through the Family Health Plus program; simplification of public program enrollment and renewal processes; and the introduction of the Healthy New York program, which targets low-income workers and small employers. Despite the gains realized through these efforts, the number of uninsured in New York remains high, with serious consequences for the uninsured, their families, and the State's entire health care system.

Of New York's estimated 2.8 million uninsured, more than two-fifths (41 percent) are already eligible for an existing public health insurance program. Another 36 percent have low-to-moderate incomes (below 300 percent of the federal poverty level [FPL]) but are ineligible for public coverage, and the remaining 23 percent have incomes above 300 percent FPL (see Figure 2).⁸ Based on these characteristics of New York's uninsured population, the *Blueprint for Coverage* includes approaches designed to increase public program participation among those who are currently eligible and to increase the affordability of health insurance coverage for low-to-moderate-income uninsured New Yorkers.⁹

Importance of Health Insurance Coverage

Understanding the magnitude of the problem of the uninsured, comprehending the risks facing those currently insured if they have inadequate coverage or lose coverage, and finding solutions to these problems is vital to ensuring the health and well-being of New York's residents, families, and communities, as well as its health care system and economy. Research from a range of sources demonstrates that the lack of health insurance coverage seriously affects the health of the uninsured and their families. In its comprehensive series of reports on the consequences of uninsurance, the Institute of Medicine (IOM) documents that the uninsured are less than half as likely as persons with insurance to receive necessary care; they are also less likely to receive appropriate care for chronic conditions or to receive preventive care in general. Health outcomes for the uninsured are consequently compromised by the lack of insurance, as diagnoses may be delayed and chronic conditions that are not properly managed may result in more severe or even disabling conditions. Uninsured persons who are hospi-

Figure 2. Total Uninsured in New York, by Eligibility for Public Health Insurance Coverage and Income



2.8 million uninsured

Source: Lewin Group estimates, based on 2005 *Current Population Survey* data trended forward to 2006.

Note: Data include persons of all ages. Numbers may not sum to 100% due to rounding.

talized receive fewer services when admitted and are more likely to die in the hospital than those who are insured. Ultimately, being uninsured contributes to an increased risk of mortality.¹⁰

The negative effects of uninsurance extend beyond the uninsured and their families to communities and the entire health care system. As the IOM describes, a high uninsured rate places a significant burden on health care providers and institutions and ultimately affects everyone who accesses the health care system, whether insured or not. Multiple studies have demonstrated that low-to-moderate-income insured residents in communities with high uninsured rates have greater difficulty in accessing health care than those in communities with lower uninsured rates. Ultimately, a high uninsured rate can reduce health care access for all community members. The financial burden of caring for a large uninsured population strains the health care system and can threaten its ability to provide high-quality health care to all community members.¹¹

The large number of uninsured residents in New York may also have significant economic

consequences for all New York residents. The costs of paying for care for the uninsured are ultimately passed down to all taxpayers and health care consumers. Government may raise taxes or divert funding for other needed services in order to obtain the revenue necessary to reimburse providers for uncompensated care. Prices for health care services, and consequently health insurance, increase in order to compensate for providing care to the uninsured. Additionally, the health consequences of being uninsured can ultimately lead to poor health and disability, which in turn may result in loss of income and dependence on public support.¹²

The IOM estimates that, at the national level, societal costs due to uninsurance are between \$65 billion and \$130 billion per year. These costs are driven primarily by poor health and increased mortality among the uninsured, but also by Medicare and disability support payments, demands on the public health system, and reduced health care service capacity.¹³ Overall, the IOM findings demonstrate that covering the uninsured is essential for improving the health of uninsured individuals and families, but it is also a necessary step toward stabilizing and improving the entire health care system.

Principles for Reform

We identified a series of principles to guide the design and assessment of potential policy options for expanding health insurance coverage in New York. These principles include the following:

- **Affordability.** Increase affordability of health insurance premiums while maintaining comprehensive benefits, so that low-income individuals and working families are able to obtain coverage that provides access to care with financial protection.
- **Administrative simplicity.** Reduce administrative complexity to make it simpler to obtain and retain public and private health insurance coverage.
- **Stability of coverage.** Reduce churning in public health insurance programs and increase overall stability of coverage.
- **Shared responsibility.** Share responsibility for the cost of coverage among individuals, employers, and federal and state government.
- **Continuity with existing programs.** Build on existing programs in New York.
- **Choice.** Provide several coverage options.
- **Pool risk.** Reduce non-group and small-group purchase of coverage in favor of pooled options to spread risk and increase bargaining clout through a large risk pool.
- **Efficiency and quality.** Provide a foundation for increasing efficiency and quality of New York State's entire health care system to benefit all New Yorkers, insured and previously uninsured. Covering the uninsured is a critical step toward accomplishing these goals.

Strategies for Expansion

We selected potential coverage expansion strategies for modeling in the *Blueprint for Coverage* based on these principles for reform as well as the characteristics of New York's uninsured population and problems with current sources of group coverage, as described above.

PUBLIC PROGRAM SIMPLIFICATION The first strategy advanced in the *Blueprint* focuses on expanding coverage for the 1.2 million uninsured New Yorkers who are already eligible for public health insurance programs. Specifically, we sought to achieve this through simplification of the enrollment and recertification processes for public health insurance programs to make it easier for persons who are eligible to enroll and retain public coverage; this would also align with the goal of reducing churning in public health insurance programs. In recent years, New York State implemented a range of policies to simplify and streamline public program enrollment and renewal.¹⁴ For the *Blueprint*, we selected four new simplification strategies that build on prior reforms and have the greatest promise for further increasing participation in New York's public health insurance programs (see "Voluntary Public Program Changes Modeled").

In selecting these strategies, we considered which simplification measures have had the greatest impact on enrollment in other states, how states have balanced simplification reforms with program integrity, and whether changes would be eligible for federal matching payments. Another important consideration in public program simplification is the trade-off between limiting "crowd-out" of employer-sponsored insurance (ESI) and promoting equity among New Yorkers purchasing coverage. The concern about equity is particularly relevant as we move beyond voluntary strategies to mandatory coverage scenarios, as discussed later in this report. Finally, while we did not specifically model such a provision, the implementation of an electronic application system would make the public health insurance enrollment processes more efficient and effective.

AFFORDABILITY OF COVERAGE A second *Blueprint* strategy is to increase the affordability of coverage for uninsured New Yorkers who are not currently eligible for public coverage but

VOLUNTARY PUBLIC PROGRAM CHANGES MODELED

Simplification of public program application and renewal procedures

- Self-declaration of income. Allow individuals to self-attest to income instead of submitting documents to prove income levels.
- Express lane eligibility. Notify Food Stamp recipients who appear to be eligible of potential eligibility for Medicaid/Child Health Plus; share data with Medicaid/Child Health Plus to avoid duplicating information and documentation.
- Administrative renewal. Conduct detailed renewal process every other year, with postcard renewal in interim years.
- Asset test. Remove the asset test as an eligibility requirement for Medicaid and Family Health Plus.

Expansion of Family Health Plus eligibility

- Expand FHP eligibility to 150 percent FPL for childless adults, aligning their eligibility with that of parents.

Subsidized buy-in to FHP

- Allow people with income between 150 percent and 300 percent FPL to buy in to FHP with income-related sliding-scale premium assistance.
- Coverage is purchased through the Insurance Exchange.
- Sliding-Scale Subsidy Schedule:

<150% FPL	100% subsidy
150%-200% FPL	80% subsidy
201%-250% FPL	65% subsidy
251%-275% FPL	50% subsidy
276%-300% FPL	25% subsidy
>300% FPL	0% subsidy
- No waiting period required.

These three voluntary public program changes are the building blocks for further reform. All mandatory policy changes described later are modeled with these building blocks in place. (See Appendix B for a discussion of The Lewin Group's modeling assumptions.)

have low to moderate incomes. The public program changes, as well as the mandatory coverage expansion strategies discussed in later sections, take into consideration the need to make coverage more affordable for those with limited incomes. To achieve this, we designed two new features: an expansion of FHP eligibility for childless adults and a buy-in to FHP with premium subsidies for New Yorkers with low to moderate incomes (below 300

percent FPL). In developing the buy-in strategy, we considered a number of design options. We selected FHP as the buy-in program because it is an existing program with a comprehensive benefits package.¹⁵ For purposes of equity, this subsidized buy-in option would be uniformly available to persons at the same income level, regardless of prior coverage status. We chose to model this as an individual buy-in rather than an employer buy-in because

subsidies can be more efficiently targeted to individuals than to employers, despite the fact that an employer buy-in could help retain employer contributions. An alternative formulation would allow employers to buy in to FHP or to support employee purchase of coverage through the buy-in.

PURCHASING MECHANISM The buy-in design also compels a third core *Blueprint* strategy: the creation of a purchasing mechanism that would provide individuals with a choice of coverage options at group rates. This entity, called an Insurance Exchange (the Exchange), provides a foundation for New York to offer coordinated options and plan choices to individuals and small groups. It also could be expanded beyond FHP plans to Healthy New York, and other plans meeting minimum standards that insurers choose to offer through the Exchange.

The Exchange also provides a vehicle to offer more affordable coverage. All enrollees in the Exchange would be charged a “pooled” group rate, and two forms of income-related subsidies would be available for FHP:

- Sliding-scale premium subsidy for those with income below 300 percent FPL;
- Premium contribution cap¹⁶ of:
 - No more than 8 percent of income for persons with income below 400 percent FPL;
 - No more than 10 percent of income for persons with income above 400 percent FPL.

The FHP buy-in (and the employer pay-or-play provisions described below) would significantly increase enrollment into the Exchange. Because of the complexity of the associated administrative responsibilities and questions about the capacity of existing plan networks, the Exchange would administer the FHP buy-in program. The Exchange would be responsible for a range of administrative functions, including enrollment, eligibility

determination for subsidies, collection of premium payments through payroll deductions, and administration of the premium subsidies through the tax system.

The Exchange is envisioned as a way to bring low-income uninsured persons into group coverage, offer a choice of plans for employees working for small employers, and address problems for moderate-income persons by making affordable and stable coverage available to all. Because of this design, including the premium assistance, the Exchange should attract enrollment while limiting adverse selection (the disproportionate enrollment of persons with high risk of poor health). Further, because people of all incomes could buy in to coverage through the Exchange, this would allow for seamless transitions as workers change jobs or if eligibility for subsidies should change. We envision that insurers would offer additional coverage options here and that the Exchange would increasingly be seen as a source of reliable coverage for small groups and individuals. Ultimately, employers—in addition to individuals—would be permitted to purchase coverage through the Exchange. As the number of enrollees grows, the Exchange would have the potential to realize significant administrative efficiencies and be a vehicle for improving quality, containing costs, and improving value.

COVERAGE MANDATES The initial public expansion would result in a substantial decrease in the uninsured yet still leave two million uninsured New Yorkers. To achieve universal coverage, additional expansion strategies would have to be employed. We also, therefore, considered coverage mandates—on employers and on individuals—as our fourth and fifth *Blueprint* strategies.

One option we considered is an employer pay-or-play approach, whereby employers with 10 or more employees would contribute 8 percent of payroll or receive a credit toward this assessment for coverage offered. This approach was designed to meet the constraints

imposed by the Employee Retirement and Income Security Act (ERISA).¹⁷ We also examined how a smaller assessment, similar to that recently enacted in Massachusetts, would affect coverage expansion and financing. This “modest” assessment is designed to cover the bad debts of uninsured workers and dependents. Because these provisions would be implemented after the public program changes described above, workers whose employers chose to pay an assessment instead of directly providing ESI would have additional affordable coverage options available to them through the Exchange. Furthermore, additional subsidies would be available once the mandates are introduced. Premium contributions would be capped at 8 percent or 10 percent of income for coverage purchased through the Exchange, a provision that would help to make coverage more affordable for persons at all income levels (see “Mandatory Policy Changes Modeled,” page 14, for more detail on the premium contribution caps).

We explored an individual mandate as a second variant of mandated coverage because the modeling indicated that such a requirement would be necessary to achieve universal coverage. We designed the individual mandate to follow the public expansions and creation of the Exchange so that provisions to ease access to public coverage and increase the number of affordable coverage options would be in place before imposing a mandate. The individual mandate would be implemented with automatic enrollment through the tax system, whereby individuals would be automatically enrolled in the coverage for which they are eligible. Income-related premium assistance could also be administered through the tax system.

If implemented in tandem, the employer requirement (either pay-or-play or the modest assessment) would help fund the coverage expansion while the individual mandate approach would ultimately achieve universal coverage in New York. We envision that the employer and individual mandates would be implemented after the Exchange had matured

to the point that a range of coverage options would be available, including the FHP buy-in, Healthy New York, and other private plans, as described above.

Part II. Modeling Specifications and Results

Building Blocks for Coverage: Voluntary Public Program Changes

In designing the *Blueprint for Coverage* around the strategies described above, we used what we refer to as “building blocks” for coverage. Under the building block approach to reform, changes would first be made to public programs in order to enroll persons who are currently eligible on a voluntary basis. Simplification of public program enrollment and renewal would be implemented to enroll currently eligible but uninsured persons. An expansion of eligibility for coverage would also be introduced to enroll childless adults whose income is just above current eligibility levels. In addition, a subsidized buy-in to FHP would make affordable coverage available to additional moderate-income New Yorkers. In this way, New York would make subsidized coverage available to more of the population in order to begin to address the issue of affordability before considering mandatory coverage options.

The goal of these building blocks—what we refer to, throughout this report, as public program changes—is to cover as many New Yorkers as possible on a voluntary basis. The *Blueprint* models these options individually to determine their independent effects and then together in a “combined public program” policy scenario to show what would happen if they were introduced at the same time. The combined public program policy changes represent the foundation upon which mandatory reform options are designed and modeled.

SIMPLIFICATION OF PUBLIC PROGRAMS

Policy Change. The first public program building block modeled is a combination of four policy changes intended to simplify the application and renewal process in New York's public health insurance programs. These changes include three simplification strategies and the removal of an eligibility requirement:

- **Self-declaration of income.** Individuals applying to any public health insurance program would be allowed to self-attest to income instead of submitting documents to prove their income levels. State Medicaid agencies would verify self-declared income using existing databases as well as random quality control audits.¹⁸
- **Express lane eligibility.** Food Stamp recipients and applicants who appear to be eligible for public health insurance coverage based on their income would be notified by an eligibility worker of their potential eligibility for Medicaid, FHP, or CHP, and be referred to the appropriate program. With the recipient's permission, the Food Stamp program would also share data with the appropriate program so that the recipient would not have to provide duplicate information and documentation.¹⁹
- **Administrative renewal.** Medicaid, Family Health Plus, and Child Health Plus recipients would undergo a detailed eligibility review and recertification process every other year, with postcard renewal in interim years. In those administrative renewal years, recipients would be mailed a postcard asking whether their income or other circumstances had changed. Recipients would be required to return their postcards, and those reporting no changes would be recertified for another year without further action.²⁰
- **Eliminate the asset test from community Medicaid and Family Health Plus.** This policy change represents the removal of an eligibility requirement, rather than a program

simplification. While there is no asset test for children in Child Health Plus A (Medicaid for children) or Child Health Plus B (SCHIP), there is an asset test in place for adults applying for Medicaid or Family Health Plus.²¹ This policy change would eliminate the asset limit for non-elderly, non-disabled adults.

Findings. The combined simplification measures would enroll approximately 310,000 uninsured New Yorkers into a public health insurance program. In total, 480,000 adults and children would enroll in a public health insurance program—two-thirds of them having been uninsured and one-third having left employer-sponsored or non-group coverage.

The total government cost of these simplification reforms would be \$810 million.²² This cost would be shared by the state and federal government, with the state responsible for approximately \$390 million and the federal government for \$420 million in federal matching funds. These figures include the costs for covering the new enrollees under the new policies, net of approximately \$60 million in administrative savings that would result from the reduced paperwork and decreased administrative burden for the state (Table 1).

The results presented here are for the combined simplification policies. For the impact and costs of each of the individual simplification measures, see the detailed Lewin Group report.

New Public Coverage Enrollment

310,000 uninsured
120,000 with employer-sponsored coverage
50,000 with non-group coverage
<hr/>
480,000 newly enrolled in public coverage

The modeling of these public program simplifications was based on evidence from other states that have implemented similar reforms. This evidence is limited because states often introduce multiple simplification reforms simultaneously or in combination with

Table 1. Public-Sector Costs (and Savings) of the Public Program Simplification Reforms (millions)

	Costs for New Enrollees	Administrative Costs	Total Net Costs	Federal Share	State Share
Total	\$870	(\$60)	\$810	\$420	\$390

other public program changes, making it difficult to distinguish the effect of an individual reform. These estimates are likely to be conservative and the actual coverage effects of simplification could be greater.

EXPANSION OF FAMILY HEALTH PLUS ELIGIBILITY

Policy Change. The second public program building block modeled is an eligibility expansion of the FHP program to cover childless adults with family incomes up to 150 percent FPL. Currently, the FHP income eligibility level for childless adults is 100 percent FPL, while parents are eligible with incomes of up to 150 percent FPL. Therefore, the expansion would align eligibility for childless adults with that of parents. (See Appendix A for further information about public program eligibility.)

Findings. Raising the FHP eligibility level for childless adults would cover 210,000 uninsured New Yorkers. In total, 320,000 New Yorkers would enroll in FHP due to this eligibility expansion, but approximately one-third of the new enrollees (110,000) would be persons who had private coverage.

Two-thirds of the new FHP enrollees would be childless adults who become newly eligible due to the eligibility expansion, while the remaining one-third were eligible but unenrolled in FHP and would now enroll due to increased awareness of the program (Table 2).

The cost to government for this FHP expansion would be approximately \$1 billion. In the modeling, it is assumed that federal matching funds would only be available for persons who are currently eligible, not for those whose coverage would require a federal waiver. The state would therefore be responsible for approximately \$860 million and the federal government for approximately \$160 million in matching funds (Table 3).

SUBSIDIZED BUY-IN TO FAMILY HEALTH PLUS

Policy Change. The third public program building block modeled is a subsidized buy-in to FHP. In this policy scenario, individuals and families with incomes between 150 percent and 300 percent FPL could buy in to FHP with sliding-scale premium assistance based on family income. Persons with income above 300 percent FPL could purchase FHP at full premium. Benefits and co-payments for

Table 2. New Family Health Plus Coverage Due to Expansion

	Total	Previously Uninsured	Previously with ESI	Previously with Non-group
Newly Eligible Adults	210,000	110,000	70,000	20,000
Currently Eligible Adults	110,000	100,000	10,000	10,000
Total	320,000	210,000	80,000	30,000

Note: Numbers do not sum to totals due to rounding.

Table 3. New Public-Sector Costs of the Family Health Plus Expansion (millions)

	Costs for New Enrollees	Federal Share	State Share
Newly Eligible Adults	\$720	–	\$720
Currently Eligible Adults (Spillover Effect)	\$300	\$160	\$150
Total	\$1,020	\$160	\$860

Note: Numbers do not sum to totals due to rounding.

those buying in to FHP would be the same as for those participating in the fully subsidized FHP program. To promote equity, no waiting period would be imposed for those with existing health insurance coverage.

The sliding-scale premium subsidy schedule would be:

Income as Percent of FPL	Subsidy
<150% FPL	100%
150%-200% FPL	80%
201%-250% FPL	65%
251%-275% FPL	50%
276%-300% FPL	25%
>300% FPL	0%

Based on this sliding scale it is estimated that:

- A parent in a household of two with income of \$20,000 would contribute approximately \$600 per year toward coverage, or \$50 per month.
- A childless adult in a household of two with income at \$34,000 per year would pay \$2,100 per year, or \$175 per month.
- A two-parent, two-child family of four with income of \$51,000 would spend about \$4,800 per year, or \$400 per month.

(See Appendix A for additional estimates of individual and family premium contributions by income level.)

Findings. In total, 1.4 million New Yorkers with incomes between 150 percent and 300 percent FPL would enter the subsidized FHP buy-in. The net reduction in the number of uninsured under this scenario would be 340,000.²³ The reduction in the uninsured includes people who had been uninsured and

who enrolled in the buy-in, net of a small number of people who would become uninsured because their employers discontinued coverage with the availability of subsidized coverage through the buy-in, as described below. Nearly three-quarters (71 percent) of the new buy-in enrollment would be people who had private coverage, either employer-sponsored or non-group coverage.

As shown in these findings, the availability of subsidized coverage with neither an assessment on employers for dropping coverage nor a waiting period for individuals with existing coverage leads to a significant shift away from employer-sponsored insurance and into the FHP buy-in. It is assumed that individuals drop ESI and enroll in the buy-in if it is cost-effective to do so, and that employers stop offering coverage if their workers, on average, would pay less in the FHP buy-in than under ESI (see Appendix B for modeling assumptions). However, not all workers whose employers drop coverage enroll in the buy-in; some would be eligible for and enroll in fully subsidized public coverage, while a small number would become uninsured.

The total cost of the subsidized FHP buy-in is \$5.1 billion, including approximately \$4.0 billion in state subsidies and nearly \$1.2 billion in premium payments from families (Table 4). Again, these estimates assume that no federal matching funds are available to fund the buy-in. Potential financing options, including federal financial participation for the buy-in, are discussed later.

Table 4. Public-Sector and Family Costs of the Subsidized FHP Buy-In (millions)

Total Costs	State Subsidies	Family Premium Payments
\$5,120	\$3,970	\$1,150

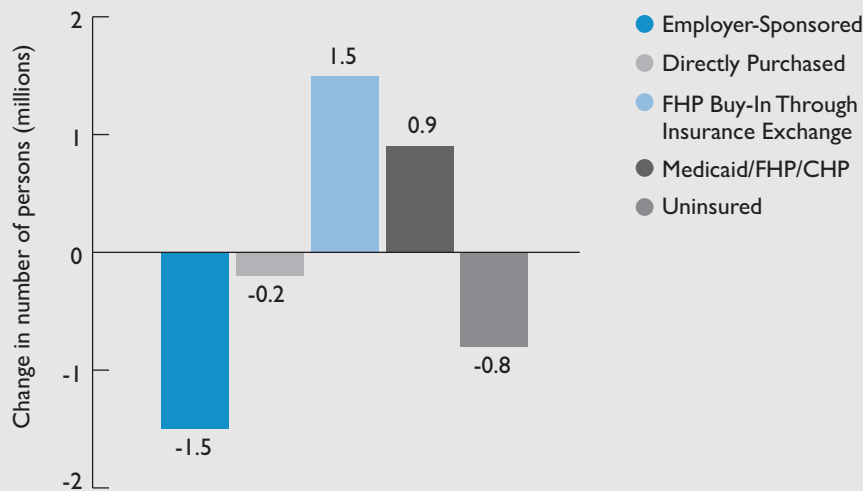
COMBINED PUBLIC PROGRAM CHANGES

All of the public program changes would be implemented before introducing mandatory coverage policies. This approach aims to cover as many New Yorkers as possible on a voluntary basis by enrolling the eligible but uninsured through simplification, raising FHP eligibility levels for childless adults, and increasing the affordability of coverage for moderate-income New Yorkers through the FHP buy-in. Since there would be some overlap between the populations targeted by these policies, we modeled a scenario in which these changes are made simultaneously. This “combined public program” scenario reduces the number of uninsured New Yorkers by 840,000, a nearly one-third reduction in New York’s uninsured population, with approximately half of those 840,000 formerly uninsured enrolling in the FHP buy-in through the Exchange and half

enrolling in public coverage (see Figure 3). These changes result in large enrollment increases in public programs and the FHP buy-in through the Exchange. A total of 950,000 people enroll in Medicaid, FHP, or CHP. Another 1.5 million people enroll in the FHP buy-in through the Exchange, including 1.2 million with incomes between 150 percent and 300 percent FPL and 350,000 people with income above 300 percent FPL who buy in at full premium. In total, nearly 2.5 million people enroll in public coverage and the FHP buy-in as a result of these policy changes. Approximately one-third of this new public program enrollment is made up of people who were uninsured, while two-thirds of the enrollees lost or left private coverage (see Figures 3 and 4).

The net cost of implementing the combined public program changes is \$1.7 billion. The

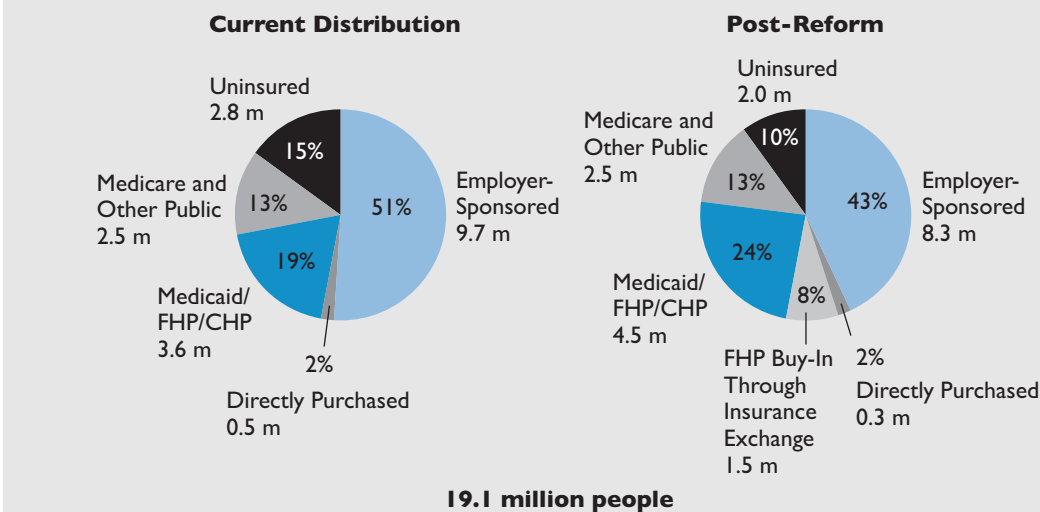
Figure 3. Coverage Shifts: Public Program Changes Combined (millions)



**840,000 newly insured;
2.0 million remain uninsured**

Note: Coverage shifts are for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and buy-in to FHP). Numbers presented in this chart may not sum to totals and may not match numbers in the text due to rounding.

Figure 4. Distribution of Health Insurance Coverage, Before and After Combined Public Program Changes



Note: "Post-Reform" scenario includes the combined administrative simplification, expansion of FHP to 150% FPL, and subsidized buy-in to FHP (150%-300% FPL). "Medicare and Other Public" category includes dual eligibles and persons covered by CHAMPUS. Data include persons of all ages. Numbers may not sum to 100% due to rounding.

incremental cost to the state would be \$4.8 billion, which includes spending for new public program enrollees and FHP premium subsidies, as well as program administration. The federal government would be responsible for increased spending of \$800 million in matching funds, while families would bear \$500 million in new premium costs. Family contributions would be higher overall under this combined policy scenario due to the fact that there are more newly insured persons who face partial or full premiums in the FHP buy-in. However, employers would experience significant savings under this scenario due to the large shifts away from ESI and into public coverage.²⁴ In total, employers would save \$4.4 billion with the combined public program changes (see Figure 5). Presumably, most of these savings would accrue to employers with low-wage workforces.

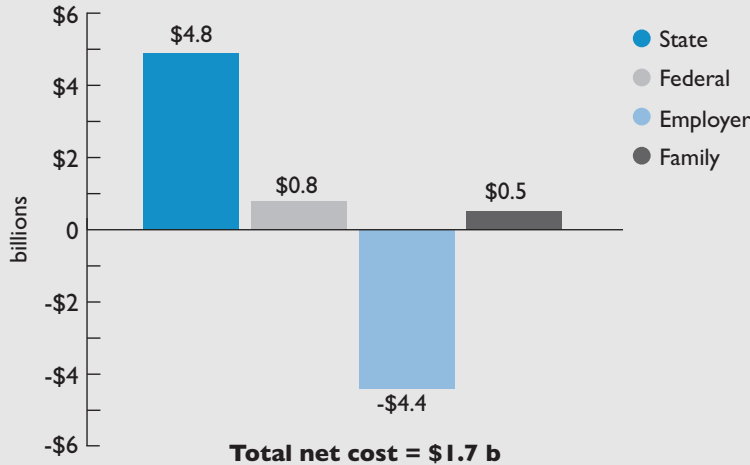
The large shifts in coverage and costs from employers to government-funded programs observed in the combined public program scenario suggest the need to consider policies to reduce these effects or to assure that financing follows the flow of people. If the public

program changes were implemented without any mandatory coverage policies, decision makers might consider introducing a waiting period in the FHP buy-in for individuals with ESI. We did not model such a waiting period because the balance of the *Blueprint* explores policies that would mandate coverage and are intended to be implemented in combination with the voluntary public program changes. Under the mandatory employer scenarios, assessments on employers would reduce the loss of ESI and provide a source of financing. Further, if individuals are required to purchase coverage, then to promote equity they must be able to take advantage of the coverage that is most affordable and best suited to their coverage needs.

Achieving Universal Coverage

Mandates are necessary to achieve universal coverage in New York. The voluntary public program changes would achieve a nearly one-third reduction in the uninsured, but still leave two million uninsured New Yorkers.

Figure 5. Net Change in Spending by Payer, Combined Public Program Changes* (billions)



Note: Net costs for each stakeholder are for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and buy-in to FHP).
 * Reflects change over current spending on health insurance.

Therefore, we examined a range of mandatory coverage scenarios, including requirements for employers to offer coverage, contribute financially toward the cost of coverage, or both, as well as mandates on individuals to purchase coverage.

As described above, voluntary public program changes—simplification reforms, eligibility expansions, and newly subsidized FHP coverage—result in a large shift of people from employer and non-group coverage into publicly sponsored coverage and coverage purchased through the Exchange. As modeled, people select the source of coverage that best meets their needs without a penalty for switching between coverage sources. Provisions that either mitigate this shift and/or help to finance the new coverage options are put into place under the following “mandatory” coverage scenarios. These include a range of assessments on employers not offering coverage (non-offering employers) that either induce more employers to offer coverage directly or raise revenues to pay for coverage obtained through the Exchange, as well as a

mandate on individuals that compels enrollment into available coverage and results in increased demand for ESI. In the scenarios that include an employer requirement, employers ultimately finance a significant portion of enrollment through the Exchange, so we do not describe this shift from ESI to the Exchange as a loss of employer coverage but rather as providing a new coverage option that is at least partially funded by employers.

When selecting the mandatory scenarios to model, we considered lessons from other states. In recent years, state efforts to expand health insurance coverage have focused on models that would increase employer responsibility for coverage.²⁵ These efforts have been unsuccessful for a number of reasons: these initiatives have been met with significant resistance from the business community, and research in at least one state concluded that the program’s design would have limited impact on coverage rates.²⁶ More recently, states have begun to explore the idea of mandates on individuals to directly purchase or take up health insurance coverage offered.²⁷

MANDATORY POLICY CHANGES MODELED

Employer Requirement

Two scenarios, employer pay-or-play and a modest employer assessment, were modeled as alternative approaches to an employer requirement.

Employer pay-or-play

- Employers with 10 or more workers are assessed an 8 percent payroll contribution. A credit is given to employers that provide health insurance coverage and contribute at least 60 percent of the premium.
- Employees can purchase subsidized FHP coverage through the Insurance Exchange. Available coverage in the Exchange includes Family Health Plus, Healthy New York, and other plans insurers decide to offer through the Exchange.
- Family premiums for FHP coverage purchased in the Exchange are subsidized in two ways: 1) income-related sliding-scale premium subsidies for those with income below 300 percent FPL, and 2) a cap on total premium contributions of 8 percent of income for persons with income below 400 percent FPL and 10 percent of income for persons with income above 400 percent FPL.

Modest employer assessment

- Employers with 10 or more workers that do not provide health insurance coverage and contribute at least 60 percent of the premium will be required to pay a modest annual assessment of \$400 per worker to the state.
- Insurance Exchange and subsidy provisions described earlier are also in place.

Individual Mandate

This scenario was modeled alone and in combination with pay-or-play or the modest employer assessment.

- Everyone in New York State is required to purchase health insurance coverage.
- Individuals who do not enroll in coverage voluntarily are auto-enrolled into coverage for which they are eligible and charged the premium owed.
- The subsidy structure is the same as under the employer pay-or-play scenario described above.
- The mandate is enforced through the tax system. The modeling assumes that all people in families with tax filers will take coverage through their employer, Medicaid/FHP, or the Insurance Exchange.

All of these policy scenarios are modeled in combination with the voluntary building block changes described earlier. The modeling results indicate that the three scenarios that include an individual mandate would achieve universal coverage.

Research pertaining to health care reform efforts in Massachusetts in particular demonstrated that an individual mandate would be necessary—either alone or in conjunction with an employer requirement—in order to reach universal coverage.²⁸ This past April, Massachusetts enacted the Massachusetts Health Reform Act of 2006, which includes a public program expansion, employer responsibility provisions, and an individual mandate.²⁹ This combination of reforms represents one model for achieving universal coverage on a state level and is attractive because, importantly, it reflects a critical compromise reached among stakeholders in the business, government, provider, and advocacy communities that has not been achieved elsewhere.

INDIVIDUAL MANDATE WITHOUT EMPLOYER REQUIREMENT

An individual mandate would have a significant impact on coverage rates. When implemented in combination with the voluntary public program changes, an individual mandate would cover 2.4 million of the 2.8 million uninsured New Yorkers. These coverage gains occur through increased take-up of employer-sponsored insurance and public coverage, as well as significant enrollment through the Exchange. An individual mandate increases employee demand for ESI and thereby induces more employers to offer coverage, and some workers who previously declined an employer coverage offer would now participate. Further, as designed here, all of those eligible for public coverage would be automatically enrolled into the appropriate public program.

Because there would be no assessment on non-offering employers in this scenario, the distribution of spending under the individual mandate scenario is skewed toward the state. The overall net cost of this policy scenario is \$4.2 billion. Employers would save \$4.1 billion, while the state government would be responsible for \$6.2 billion, the federal government would spend \$1.2 billion, and

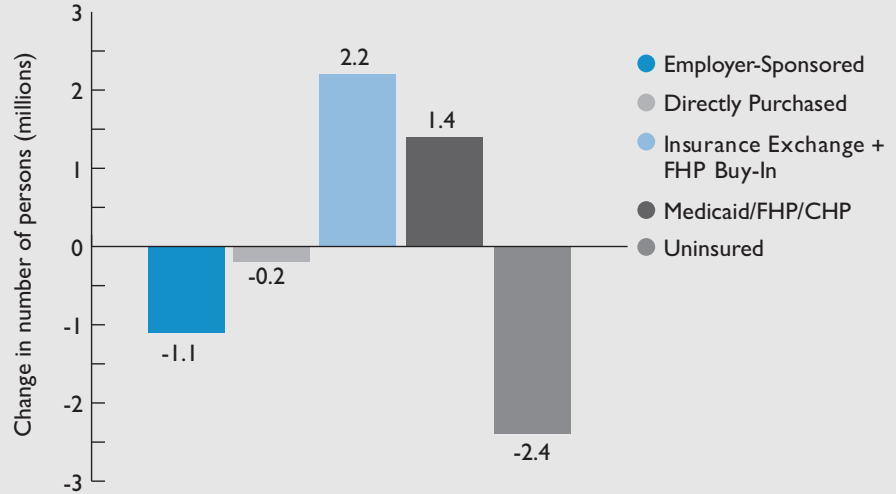
families would spend \$900 million more than under current law. These net costs are very similar to those under the modest employer assessment scenario (described below) because the effect of having no employer penalty is similar to that of a small penalty. The incremental differences in net costs to the state and employers between these two scenarios are a result of the assessment, which induces a small number of employers to offer ESI directly.

APPLYING THE MASSACHUSETTS MODEL TO NEW YORK

We modeled a policy scenario for New York that closely resembles the Massachusetts health care reform act: voluntary public program changes in combination with a modest assessment on employers and an individual mandate (see “Comparing New York and Massachusetts,” page 22). Our modeling results indicate that this combination of policy reforms would reach 2.4 million of the 2.8 million uninsured New Yorkers, achieving a 98 percent coverage rate (see Figures 6 and 7). As described above, the voluntary public program changes would result in a shift of people from employer and non-group coverage into the public programs and the Exchange. The addition of an individual mandate in this scenario would compel a significant increase in take-up of available coverage, driving the reduction in the number of uninsured. Because the assessment on employers who do not offer coverage is small under this scenario, it would not provide an incentive for many employers to newly offer coverage. As a result, there would be no direct impact on coverage rates from the assessment itself. The employer assessment would, however, raise \$400 million in revenues that would be used to offset the state’s cost of the coverage expansions. (The 390,000 people who would remain uninsured are non-tax filers who cannot be enrolled through the tax system.)

The overall net cost of this reform proposal is \$4.1 billion. New York State would contribute \$5.5 billion in new spending, mostly toward

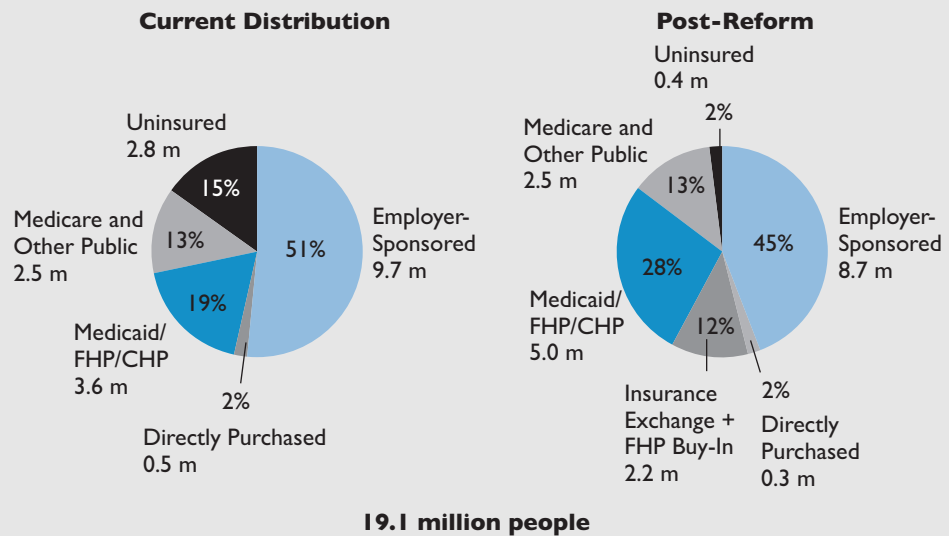
Figure 6. Coverage Shifts: Modest Employer Assessment with Individual Mandate and All Public Program Changes (millions)



**2.4 million newly insured;
390,000 remain uninsured**

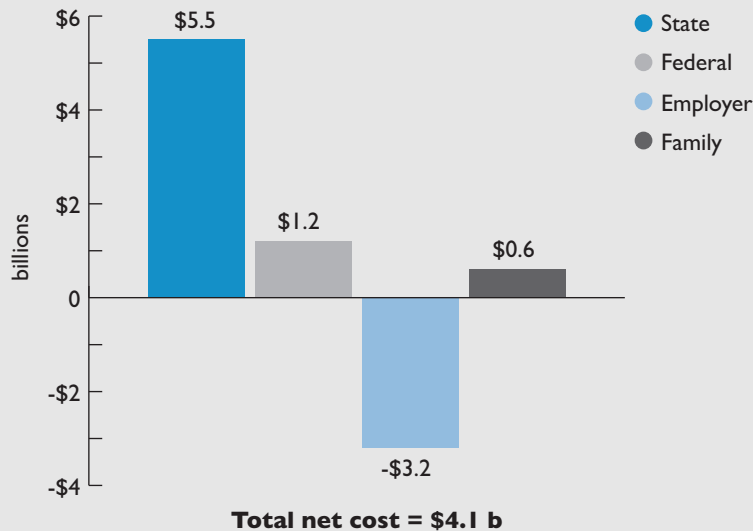
Note: Numbers presented in this chart may not sum to totals and may not match numbers in the text due to rounding.

Figure 7. Distribution of Health Insurance Coverage, Before and After Modest Employer Assessment



Note: "Post-Reform" scenario includes administrative simplification, expansion of FHP to 150% FPL, subsidized buy-in to FHP (150%-300% FPL), individual mandate, and modest employer assessment. "Medicare and Other Public" category includes dual eligibles and persons covered by CHAMPUS. Data include persons of all ages. Numbers may not sum to 100% due to rounding.

Figure 8. Net Change in Spending by Payer: Modest Employer Assessment with Individual Mandate and All Public Program Changes (billions)



subsidies for coverage purchased through the Exchange. The federal government would contribute \$1.2 billion in Medicaid, FHP, and Child Health Plus matching payments for currently eligible public program enrollees. Families would spend \$600 million more than under current law because of premium requirements in the Exchange. Despite the modest assessment, employers would save \$3.2 billion because many currently offering employers would drop coverage as a result of the availability of subsidized coverage in the Exchange. Currently insuring employers (those who offer and whose employees take up ESI) would save \$3.6 billion and currently non-insuring employers would spend \$400 million more than they would under current law (see Figure 8).

EMPLOYER PAY-OR-PLAY WITH AND WITHOUT AN INDIVIDUAL MANDATE We also modeled an employer pay-or-play scenario in which non-offering employers would contribute 8 percent of payroll, an amount that approximates the typical contribution toward an individual premium by employers that now finance health benefits for employees.³⁰ This

option builds on a “Creating Consensus” proposal that shares responsibility among employers, as well as with federal and state governments and individuals.³¹ The pay-or-play policy itself (without an individual mandate) has a modest impact on the uninsured: only an additional 130,000 previously uninsured New Yorkers would gain coverage under this scenario. This is because most employees who would gain ESI as a result of this policy would shift from another source of coverage. An advantage of this approach is that it raises \$1 billion in employer assessment revenue to help offset the cost of other reforms. The pay-or-play approach also results in a greater number of employers continuing to offer coverage directly than with a more modest assessment.

When an employer pay-or-play requirement is implemented in combination with an individual mandate and the aforementioned public program changes, 2.4 million previously uninsured New Yorkers are covered. Importantly, because employers are assessed more than in the modest assessment scenario, more employers provide coverage directly. Therefore, these coverage gains are achieved at a lower cost to both the state and to families

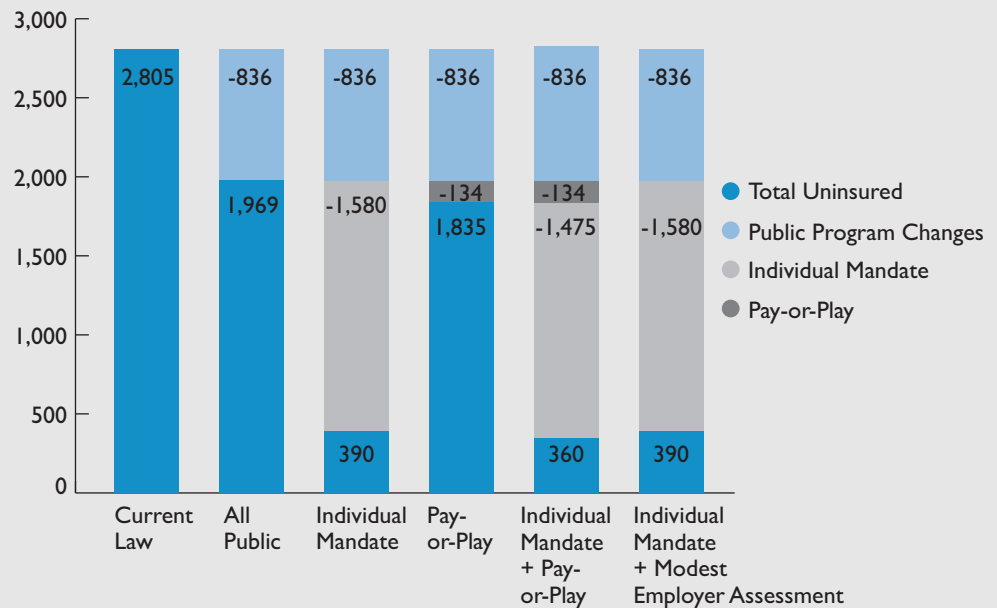
compared with the modest employer assessment scenario. The net cost of this scenario is \$4.1 billion. The state would be responsible for \$4 billion and the federal government for \$1 billion in new spending. Employers would save \$600 million overall: spending by currently insuring employers would decrease by \$1.7 billion as some drop coverage and instead pay the assessment, and currently non-insuring employers would see an increase in spending of \$1.1 billion on newly offered coverage or assessments. Finally, families would save \$300 million compared with current law. Employers pay more under pay-or-play than under the modest employer assessment scenario because more would provide coverage directly; state government pays less because fewer people requiring subsidies would be enrolled through the Exchange; and families pay less because more would have ESI, where premium requirements are lower, than subsidized FHP through the Exchange.

Summary of Changes in Coverage and Spending

The voluntary public program changes modeled achieve a nearly one-third reduction in the uninsured, leaving two million New Yorkers uninsured (see figure 9).

Despite the fact that nearly half of uninsured New Yorkers are eligible for existing public programs, the implementation of select simplification reforms was found to achieve only modest coverage gains. (As discussed above, these estimates are limited by the available evidence and should be considered to be conservative.) The FHP eligibility expansion would successfully enroll a number of newly eligible adults. In addition, because of increased awareness due to the expansion, this policy would encourage a number of already eligible adults to enroll. The availability of subsidized coverage through the FHP buy-in would result in a shift from employer-sponsored

Figure 9. Incremental Change in Uninsured by Policy (thousands)



coverage into this new coverage option. In order to distribute the costs of coverage expansions across payers, a range of employer penalties were modeled: from no employer requirement under the individual mandate, to a modest assessment, to an assessment of 8 percent of payroll on non-offering employers.

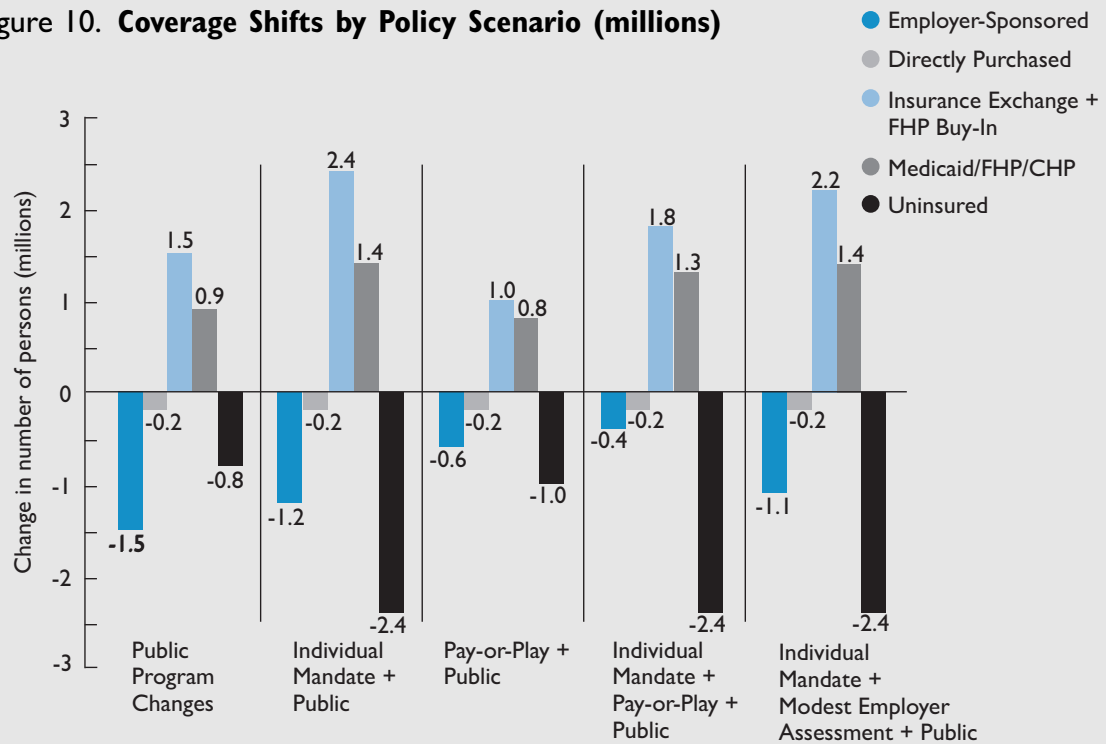
Regardless of the specific approach, significant subsidies are needed to gain participation by low-income persons, as has been well documented in the research literature and in practical experience.³² As designed here, individuals would pay an income-related premium contribution toward FHP. For example, a parent in a family of two earning \$20,000 would pay 3 percent of income, while a parent in a family of two earning \$50,000 would pay 6 percent of income. The premium caps provide a second source of subsidy and are especially important for persons at the upper end of the sliding scale and for families because premiums represent a greater share of their income. Without the premium contribution cap, for example, a family of four earning \$61,000 per year would pay \$9,600 in annual premiums, or 16 percent of income. With the premium contribution cap at 8 percent of income, the same family's premium cost would be \$4,800 per year. (See Appendix A for additional estimates of individual and family premium contributions by income level.) The modeling results indicate that the bulk of the enrollment into the Exchange would be among persons with income below 300 percent FPL, where subsidies are greatest. However, while the FHP subsidies drive significant costs for the state government, the premiums may still be unaffordable for some low-income persons.

SHARED RESPONSIBILITY Overall net costs are greater for families under the public program changes, the individual mandate, and the modest employer assessment scenarios, compared with current law, largely because more uninsured persons would have coverage. The modeling results indicate that under all scenarios there would be increased utilization of services among the newly insured, as well as a modest increase in utilization among the currently insured because of improved coverage. However, even once covered, the previously uninsured would still cost less than those who are currently insured because those with greater health needs are more likely to be already enrolled in coverage.³³ Thus, the cost of universal coverage is lower than what might be expected based on health spending for the currently insured.

Between 1 million and 2.4 million people would enroll in the FHP buy-in through the Exchange, depending upon the specific policy scenario. The Exchange essentially provides a new place for people to purchase both subsidized and unsubsidized health insurance coverage and would also serve a variety of administrative functions, including eligibility determination for subsidies and premium collection. As the Exchange grows and includes additional coverage options, it will increasingly be seen as a more affordable and stable alternative to small-group and non-group coverage. Because of its size, the Exchange would have the potential to realize significant administrative efficiencies. Further, because coverage in the Exchange would not be tied to employment and because people of all incomes could purchase coverage there, people could remain continuously enrolled regardless of changes in circumstances. For these reasons, the Exchange could help New York realize the goals of increasing administrative simplicity and stability of coverage.

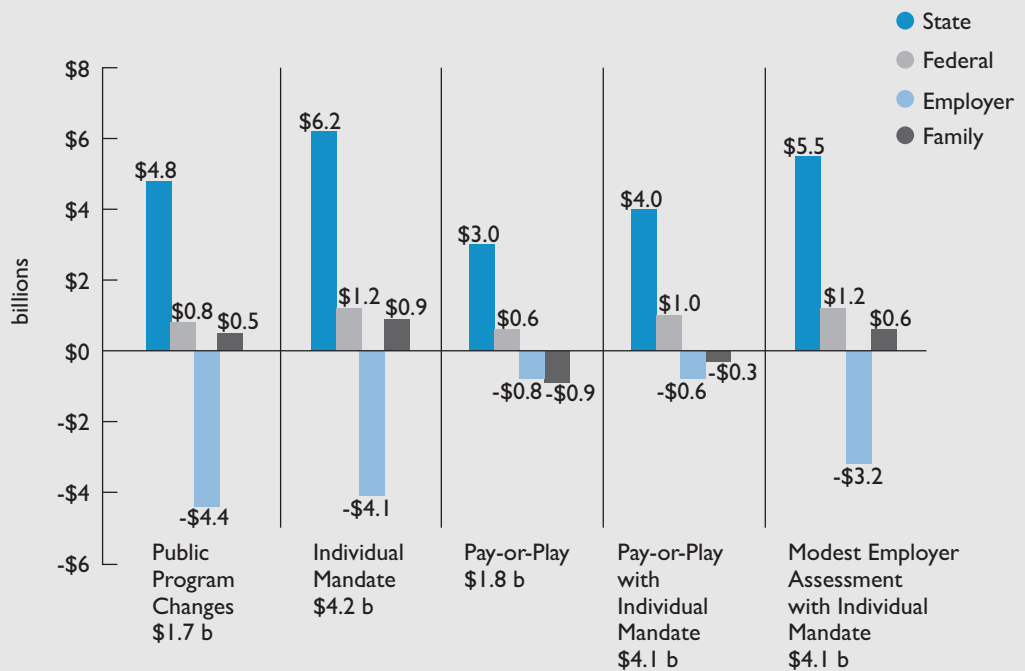
The modeling demonstrated that employer responsibility provisions have more of an impact on “who pays” than on directly

Figure 10. Coverage Shifts by Policy Scenario (millions)



Note: Coverage shifts for Pay-or-Play, Individual Mandate, Pay-or-Play with Individual Mandate, and Modest Employer Assessment with Individual Mandate scenarios include coverage shifts for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and FHP buy-in). Numbers presented in this chart may not sum to totals and may not match numbers in the text due to rounding.

Figure 11. Net Change in Spending by Payer* (billions)



Note: Costs for Pay-or-Play, Pay-or-Play with Individual Mandate, Individual Mandate, and Modest Employer Assessment with Individual Mandate scenarios also include costs for combined public reforms (administrative simplification, expansion of FHP to 150% FPL, and FHP buy-in).

* Reflects change over current spending on health insurance.

increasing coverage. For example, an employer requirement, modeled here as pay-or-play, results in coverage shifts but insignificant coverage gains, but raises significant revenue. A more modest employer assessment does not disrupt coverage patterns or result in any coverage gains, but raises less revenue to fund other expansions.

Ultimately, an individual mandate implemented with auto-enrollment is needed to achieve universal coverage (see Figure 10).

Ninety-eight percent of New Yorkers would be covered under each of the three scenarios modeled that include an individual mandate. The net cost of each of these scenarios is roughly \$4 billion. The distribution of this spending is contingent upon the degree of employer requirement (see Figure 11).

FINANCING OPTIONS There are a range of potential financing options available to raise the \$4.1 billion to \$4.2 billion necessary to achieve universal coverage in New York. First, New York could reallocate spending on the uninsured from institutional subsidies toward coverage. In 2005, New York's state and local governments spent \$1.3 billion reimbursing providers for uncompensated care.³⁴ As uninsured rates decline, a portion of these funds could be redirected toward the cost of

providing coverage directly. The federal government also provided \$942 million in Medicaid matching payments for bad debt and charity care, disproportionate share hospital, and upper payment limit programs.³⁵ Other states, such as Massachusetts, have negotiated such an arrangement with the Centers for Medicare and Medicaid Services in order to continue receiving federal matching payments for this spending.

Second, New York could seek federal financial participation (FFP) for the FHP expansion for childless adults and the subsidized buy-in to FHP for persons below 300 percent FPL. Because the modeling considered options available to New York without a change in federal policy, FFP was not assumed for either of these expansions. However, there is precedent for receipt of FFP for similar programs in other states.³⁶ New York could receive up to \$2.2 billion in federal matching funds depending upon securing the necessary federal waiver approval and demonstrating Medicaid savings elsewhere in the program. Finally, proposed federal tax credits could potentially offset premium costs for families.³⁷ All told, there is potential to offset a significant portion of the state's costs in several ways, but ultimately these coverage expansions will require new financing sources.

Conclusion

Ultimately, universal coverage would eliminate the most significant source of inequity and inefficiency from the health care system and would provide a foundation for making large-scale improvements. Coverage would

allow formerly uninsured persons to access services more easily and receive timely and appropriate care. Providers would be reimbursed directly rather than through indirect subsidies, and linking payments to

COMPARING NEW YORK AND MASSACHUSETTS

Given the passage of the Massachusetts Health Reform Act of 2006, many stakeholders have asked what a similar approach to reaching universal coverage would mean for New York. When considering the New York modeling results, it is important to remember several differences between the two states. New York has a larger share of low-income people (39 percent vs. 30 percent) and a larger share of uninsured low-income people (62 percent vs. 58 percent); a lower rate of employer-sponsored insurance (61 percent vs. 68 percent); and a larger “eligible but uninsured” population (41 percent vs. 23 percent).^{*} As a result, New York confronts a larger uninsured population, more of whom would require subsidies, and starts from a lower base of public and employer coverage than did Massachusetts.

While our “modest employer assessment with individual mandate and public program changes” scenario resembles Massachusetts’ health reform, there are some important differences in the approaches. For example, Massachusetts requires mandatory take-up of available employer coverage while the New York scenario modeled would not. Also, the coverage available through the Exchange modeled for New York is a comprehensive set of benefits for persons at all income levels, while higher-income residents in Massachusetts would likely be offered more limited coverage. Additionally, premium subsidies would phase out at a higher income level in New York than in Massachusetts.

Finally, the Massachusetts individual mandate would be implemented as a coverage requirement with penalties for non-enrollment, while the New York scenario envisions automatically enrolling people into public programs or coverage through the Exchange and charging enrollees the required premium. These differences help to explain the relative costs of reaching universal coverage in the two states. The New York approach was designed as a starting point for discussion and as such is a relatively generous proposal. Further, because of its estimated size, the Insurance Exchange could ultimately have significant negotiating power, while this is not envisioned for the Massachusetts Health Insurance Connector (the entity in Massachusetts that is similar to the New York Insurance Exchange).

^{*} Data are for 2003 and 2004 and include persons of all ages. “Low income” is defined here as no greater than 200% of the federal poverty level. The FPL for a family of three was \$14,680 in 2003 and \$15,067 in 2004. (Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau’s March 2004 and 2005 *Current Population Survey, Annual Social and Economic Supplements*. Kaiser State Health Facts, available online at www.statehealthfacts.org.) Eligible but uninsured data for New York are for 2003 and for Massachusetts are for 2004. Massachusetts eligible but uninsured rate is based on a State estimate of 460,000 total uninsured in Massachusetts. New York eligible but uninsured rate is based on the *Current Population Survey* estimate of 2.9 million uninsured in New York. (*Current Population Survey* tabulations prepared for the United Hospital Fund by the Urban Institute; see also Oakes M, April 2005, *Eligible but Uninsured: Challenges to Getting and Keeping MassHealth*, Massachusetts Medicaid Policy Institute.) Note that estimates of the uninsured and eligible but uninsured rates measured by Massachusetts state surveys are lower than those provided here.

people would allow for a greater level of accountability in the system. Further, the significant enrollment into the Exchange could make it a vehicle for driving cost control and quality reforms. Once all persons are covered, the state can approach system change to

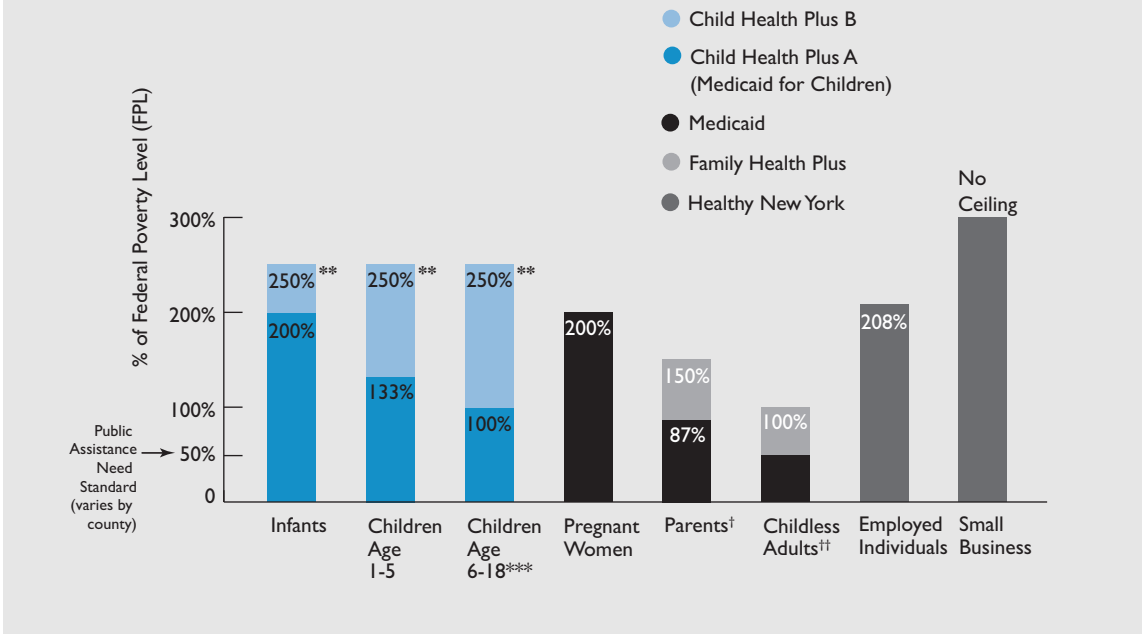
achieve the most comprehensive and effective solutions to the enduring challenges of the quality and cost of care. Universal coverage is a significant achievement in its own right. It is also a fundamental step toward realizing a high-performance health care system.

Comparing Expansion Strategies in Massachusetts and New York

MASSACHUSETTS	NEW YORK (AS MODELED UNDER THREE SCENARIOS)
Medicaid Expansion -Children to 300% FPL -Lift adult enrollment caps	Medicaid Expansion -Childless adults to 150% FPL
Insurance Connector -Individuals and small firms only -Subsidies up to 300% FPL -Mandatory take-up of employer coverage limits enrollment in the Connector -Limited potential negotiating power	Insurance Exchange -Individual buy-in -Subsidies phase out between 300%-475% FPL -No waiting period imposed -Significant enrollment expected and therefore potential for significant negotiating power
Individual Mandate -Required to purchase coverage (if affordable coverage is available) -Face penalties for non-enrollment	Individual Mandate -Auto-enrolled into coverage and assessed premium owed -Income-related premium assistance
Employer Requirement -Modest assessment per worker	Employer Requirement -Ranges from no employer requirement to 8% payroll tax
Other -Increase Medicaid rates -Insurance market reforms	
Financing -Federal matching payments -Reallocate safety net funds -Tax surplus -Employer and family contribution	Financing Not specified

Appendix A: New York State Eligibility Rules and Estimated Buy-In Contributions

New York State Eligibility Rules for Medicaid, Child Health Plus, Family Health Plus, and Healthy New York*



* Medicaid and Child Health Plus A eligibility are expressed in net income, while Child Health Plus B and Family Health Plus (FHP) eligibility are expressed in gross income, as written in HCRA 2000 and Medicaid law. The 2006 Federal Poverty Level (FPL) is \$9,800 for an individual and \$16,600 for a family of three.

** Children with gross family income above 160% FPL are charged an income-related premium. Premiums for children with gross family income of 160%-222% FPL are \$9/month/child up to \$27; for children with gross family income of 223%-250% FPL premiums are \$15/month/child up to \$45.

*** Through March 2005, the Child Health Plus A eligibility level for children ages 6-18 was 133% FPL. Effective April 2005, the Child Health Plus A eligibility level for children ages 6-18 was lowered to 100% FPL, at which time children in that age range with gross family income of 100%-133% FPL who were enrolled in Child Health Plus A were shifted into Child Health Plus B.

† "Parent" is defined as a parent of a child under 21 years who lives in the household. Medicaid eligibility includes disabled adults and 19- and 20-year-olds with net income up to 87% FPL. FHP eligibility includes 19- and 20-year-olds living with their parents, where gross family income is up to 150% FPL.

†† "Childless adult" is defined as a non-disabled adult age 21 years or over who does not have a child living in the household. FHP eligibility includes 19- and 20-year-olds not living with their parents, with gross income up to 100% FPL. Income levels for Medicaid eligibility vary by county.

Note: Low-income, uninsured women who are diagnosed with breast or cervical cancer through screenings in New York's Healthy Women Partnerships program are eligible for Medicaid coverage. Women must have income levels below 250% FPL to qualify for the screenings. Women and men of child-bearing age with income up to 200% FPL are eligible for Medicaid Family Planning Services. As of July 2003, disabled workers aged 16-64 with net income of up to 250% FPL and non-exempt resources of up to \$10,000 are eligible for Medicaid coverage through the Medicaid Buy-In for Working People with Disabilities program (MBIWPD); enrollees with incomes above 150% FPL will eventually be subject to an income-related premium.

Source: United Hospital Fund

Family Health Plus Buy-In Estimated Annual Contribution Toward Coverage, by Income, Without Premium Contribution Cap

Income	Contribution (% of premium or income)	Contribution (\$) Individual		Contribution (\$) Family of Four
		Parent (in household of 2)	Childless Adult, Age 30+ (in household of 2)	2 Parents and 2 Children
<150% FPL	0%	\$0	\$0	\$0
150%-200% FPL	20% of premium	\$600	\$800	\$1,200* (+ CHP B premiums)
201%-250% FPL	35% of premium	\$1,100	\$1,500	\$2,200* (+ CHP B premiums)
251%-275% FPL	50% of premium	\$1,500	\$2,100	\$4,800
276%-300% FPL	75% of premium	\$2,300	\$2,900	\$7,200
300% FPL	Full premium	\$3,100	\$4,200	\$9,600

Note: Estimated annual buy-in premiums are: Child—\$1,700; Parent—\$3,100; Adult <30—\$2,800; Adult 30+—\$4,200 (numbers are rounded). The 2006 federal poverty level is \$9,800 for an individual, \$13,200 for a family of two, and \$20,000 for a family of four.

* For families with income up to 250% FPL, premium estimates are for two parents only. We assume that families with income up to this level would obtain children's coverage through CHP B, where premium subsidies would be greater than the subsidies in the FHP buy-in. Annual CHP B premiums for two children range from \$0-\$216 at 150%-200% FPL and from \$216-\$360 at 200%-250% FPL, depending on income (see notes to eligibility chart for CHP B premiums). Above 250% FPL, we assumed that children would be enrolled in the FHP buy-in; however, the full CHP B premium may be less expensive than the subsidized FHP buy-in premium for families in some parts of the state.

Family Health Plus Buy-In Estimated Annual Contribution Toward Coverage, by Income, With Premium Contribution Cap

Income	Contribution (% of premium or income)	Contribution (\$) Individual		Contribution (\$) Family of Four
		Parent (in household of 2)	Childless Adult, Age 30+ (in household of 2)	2 Parents and 2 Children
<150% FPL	0%	\$0	\$0	\$0
150%-200% FPL	20% of premium (up to 8% of income)	\$600	\$800	\$1,200* (+ CHP B premiums)
201%-250% FPL	35% of premium (up to 8% of income)	\$1,100	\$1,500	\$2,200* (+ CHP B premiums)
251%-275% FPL	50% of premium (up to 8% of income)	\$1,500	\$2,100	\$4,000-\$4,400
276%-300% FPL	75% of premium (up to 8% of income)	\$2,300	\$2,900-\$3,100	\$4,400-\$4,800
301%-400% FPL	8% of income	\$3,100	\$3,200-\$4,200	\$4,800-\$6,400
>400% FPL	10% of income	\$3,100	\$4,200	\$8,000-\$9,600

Note: Estimated annual buy-in premiums are: Child—\$1,700; Parent—\$3,100; Adult <30—\$2,800; Adult 30+—\$4,200 (numbers are rounded). The 2006 federal poverty level is \$9,800 for an individual, \$13,200 for a family of two, and \$20,000 for a family of four.

* For families with income up to 250% FPL, premium estimates are for two parents only. We assume that families with income up to this level would obtain children's coverage through CHP B, where premium subsidies would be greater than the subsidies in the FHP buy-in. Annual CHP B premiums for two children range from \$0-\$216 at 150%-200% FPL and from \$216-\$360 at 200%-250% FPL, depending on income (see notes to eligibility chart for CHP B premiums). Above 250% FPL, we assumed that children would be enrolled in the FHP buy-in; however, the full CHP B premium may be less expensive than the subsidized FHP buy-in premium for families in some parts of the state.

Appendix B: Modeling Assumptions in Brief

In order to interpret the modeling results, it is important to understand the underlying assumptions. A more detailed description of these assumptions and results, including data on wage effects, is included in the report of The Lewin Group.* We briefly describe the key assumptions here.

Individual voluntary participation assumptions are based upon an analysis of public program participation rates and price elasticity estimates. Employer decisions of whether or not to offer coverage directly are based on cost-benefit analyses and composite price elasticity estimates.

Employers offer coverage to attract and retain workers and employees ultimately “pay” for employer-sponsored insurance (ESI) through reduced wages. Employers’ decisions regarding whether or not to offer coverage directly were modeled based on an assessment of what would be best for their employees: ESI or the FHP buy-in. The employer’s decision is modeled based on the cost of ESI to the workforce through reduced wages (the premium less the tax exclusion on ESI) compared with the cost of covering workers in the FHP buy-in (FHP premium less subsidies) plus a “penalty” (either a “modest assessment” or 8 percent payroll contribution), if applicable.

However, the decision of whether or not an employer offers coverage directly or individuals choose ESI over FHP (including the FHP buy-in) is not strictly an economic one. Ultimately, this decision is estimated using price elasticity estimates based on worker characteristics. Simply stated, firms employing primarily younger and healthier workers will be more price sensitive than firms employing older and sicker workers, who will be less price sensitive and therefore more likely to retain ESI.

The result is that, in general, higher-income workers are found to prefer ESI because of the associated tax benefits and because they are not eligible for the FHP subsidies. Lower-

income workers are found to prefer the FHP buy-in because the subsidies make this more cost-effective.

The same assumptions about employer and employee behavior are used in all of the policy scenarios. An important distinction between the different mandatory scenarios is the presence and scale of an employer assessment for not offering coverage: there is no assessment on employers under the individual mandate, a small assessment under the modest employer assessment, and a relatively large assessment under the pay-or-play scenario.

As discussed above, the modeling assumes that employees pay for coverage through reduced wages. If the cost of insurance for employers increases, it is assumed that wages decrease. Conversely, if the employer’s cost of insurance declines, wages would rise. The modeling projects a reduction in employer coverage and costs under all scenarios, and that, over time, these savings would be passed back to workers in the form of wage increases. These estimated wage effects would likely play out over the first two years of the program. The cost estimates presented in this report do not include the wage effects associated with these policy changes.** When wage effects are included, employers realize no net savings because these savings are passed back to workers. (As a result, families are estimated to save between \$1 billion and \$2 billion overall under the three universal coverage scenarios.) The state would still face increased costs (estimated to be between \$4 billion and \$6 billion under the three universal coverage scenarios), which could be funded through increased federal funds, redirecting current spending, and/or raising revenues.

* See The Lewin Group, December 2006, *Estimates of the Cost and Coverage Impacts of Proposals to Expand Health Insurance Coverage in New York*, prepared for the United Hospital Fund and The Commonwealth Fund. Available online at www.uhfny.org

** Note: Some of the estimates provided here differ from those in The Lewin Group report. We did not include offsets for safety net subsidies or Healthy New York program savings because we consider these to be potential state savings. We also did not include adjustments for wage effects because we consider these to be long-term effects. Finally, we did not include savings to the state when government employees shift from ESI to FHP, because such enrollment is not permitted under New York State law.

Notes

- ¹ For the purposes of this report, we describe a 98% coverage rate as “universal” coverage.
- ² See The Lewin Group, December 2006, *Estimates of the Cost and Coverage Impacts of Proposals to Expand Health Insurance Coverage in New York*, prepared for the United Hospital Fund and The Commonwealth Fund. Available online at www.uhfnyc.org.
- ³ Family Health Plus is an expansion of New York’s Medicaid program, for single adults with income up to 100% of the federal poverty level (FPL) and for parents with income up to 150% FPL. It has a more limited benefit package than the traditional Medicaid program. Child Health Plus refers to the public health insurance programs for children in New York, Child Health Plus A (CHP A) and Child Health Plus B (CHP B). CHP A is the state’s Medicaid program for children; CHP B is New York’s State Children’s Health Insurance Program (SCHIP). See Appendix A for CHP A and CHP B income eligibility levels.
- ⁴ The Lewin Group estimates of coverage distribution for New York State are based on 2005 *Current Population Survey, Annual Social and Economic Survey* data trended forward to 2006. Baseline coverage data include adjustment for under-reporting of Medicaid coverage.
- ⁵ United Hospital Fund analysis of tabulations of the 2001-2006 *Current Population Survey, Annual Social and Economic Survey*, prepared by the Urban Institute for the United Hospital Fund.
- ⁶ United Hospital Fund analysis of county-level New York State Insurance Department standardized health plan premium data. Data accessed at <http://www.ins.state.ny.us/ihmoindx.htm>. For example, between March 2003 and October 2006, the average direct-pay individual and family HMO premiums in New York City rose by approximately 60%. The average individual HMO premium in New York City rose from \$442 to \$704 per month during this period, while the average family premium rose from \$1,312 to \$2,119 per month. For direct-pay Point of Service (POS) plans in New York City, the average individual premium rose by approximately 67% over this period, from \$599 to \$1,000 per month, and the average family POS premium rose by 26%, from \$1,863 to \$2,917 per month.
- ⁷ A United Hospital Fund study found that, in 2001, 42% of children in Child Health Plus B were disenrolled at renewal, and two-thirds who did not renew coverage in 2001 were enrolled a year later (see Birnbaum M and D Holahan, 2003, *Renewing Coverage in New York’s Child Health Plus B Program: Retention Rates and Enrollee Experiences*, United Hospital Fund). Another study, from The Commonwealth Fund, found that 93% of children remain eligible for Child Health Plus B coverage at the time of recertification, despite the fact that the disenrollment rate is approximately 50% (see Lipson K, E Fishman, P Boozang, D Bachrach, 2003, *Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York’s Public Health Insurance Programs*, The Commonwealth Fund).
- ⁸ The Lewin Group estimates using the Health Benefits Simulation Model, 2006. In 2006, 300% of the federal poverty level is \$29,400 for an individual and \$49,800 for a family of three.
- ⁹ In 2006, 300% FPL for a family of three is \$49,800, while the average cost of a family health insurance premium for an HMO plan in the direct pay market in New York City is more than \$25,000. This premium represents nearly one-half of the family’s income, clearly an unaffordable expense. While the Healthy New York program provides a much less expensive alternative, with premiums closer to \$8,000 per year in 2006, individuals and families with income above 250% FPL are not eligible to participate in Healthy New York except through a participating employer. Enrollment into the Healthy New York program has been relatively low, reaching 128,000 in August 2006.
- ¹⁰ Institute of Medicine. October 2001. *Coverage Matters: Insurance and Health Care*. Institute of Medicine. May 2002. *Care Without Coverage: Too Little, Too Late*.
- ¹¹ Institute of Medicine. March 2003. *A Shared Destiny: Community Effects of Uninsurance*.
- ¹² Ibid.
- ¹³ Miller W, E Richardson Vigdor, WG Manning. March 31, 2004. Covering the Uninsured: What Is It Worth? *Health Affairs*.
- ¹⁴ Simplification and streamlining reforms include self-attestation of resources and social security number for Medicaid applications and renewals, self-attestation of income for Child Health Plus B renewals, simplified renewal forms, and elimination of the face-to-face interview for Medicaid renewal. The state has also introduced a system of facilitated enrollment to allow community-based organizations and health plans to provide assistance to public program applicants in completing application requirements and navigating the application process.
- ¹⁵ The Lewin Group estimates that the premium for “enhanced” Healthy New York (existing Healthy New York benefits plus mental health and expanded prescription drug coverage, and existing Healthy New York cost-sharing levels) would be in the range of the Family Health Plus premium because the remaining benefit and cost-sharing differences would be offset by lower administrative and provider payment rates in Family Health Plus.
- ¹⁶ The premium contribution cap applies in the employer pay-or-play and individual mandate scenarios only.
- ¹⁷ Under federal law, states can tax employers and can provide benefits for state residents; they cannot mandate that employers offer health insurance coverage to their employees. A pay-or-play approach in which employers either pay a tax or provide benefits to their employees is expected to survive an ERISA challenge.
- ¹⁸ For information on state experiences with self-declaration of income policies, see Holahan D and E Hubert, 2004, *Lessons from States with Self-Declaration of Income Policies*, United Hospital Fund.
- ¹⁹ Note that the federal income eligibility level for Food Stamps is 130% FPL (gross income), while income eligibility for public health insurance programs in New York is higher for most populations, except for childless adults. Therefore, most children and parents who are eligible for Food Stamps would be income-eligible for a public health insurance program. For a detailed analysis of potential approaches to aligning the Medicaid and Food Stamp programs in New York, see Serafi K and AM Costello, November 2006, *Coordinating New York’s Medicaid and Food Stamp Programs: Making It Easier for Families to Get the Benefits They Need*, Children’s Defense Fund-New York.
- ²⁰ Georgia and Utah have implemented similar administrative renewal policies in their SCHIP programs; families do not need to contact their state agency if nothing has changed that would affect eligibility. Hawaii and Illinois are considering similar provisions (Center on Budget and Policy Priorities, 2006).
- ²¹ In 2006, the asset test for non-elderly, non-disabled adults is \$4,150 for an individual and \$6,100 for an adult in a family of three. For Family Health Plus, the asset test is three times the aforementioned asset test, or \$12,450 for a childless adult and \$18,300 for an adult in a family of three.
- ²² We report total costs here and throughout the public program changes subsections. For the combined voluntary changes and all other scenarios, we report net costs by stakeholder compared with current law.
- ²³ Note that these results do not include persons who would buy in to FHP at full cost.
- ²⁴ Note that the modeling assumes that, over time, employer savings would be passed back to workers in the form of wage increases (see Appendix B and The Lewin Group report). Because of the tax implications associated with a shift from receiving insurance through an employer versus directly purchasing coverage, a larger policy goal would be to ensure equity in the tax treatment for the direct purchase of health insurance coverage.
- ²⁵ These have included California’s Health Insurance Act of 2003 and Maryland’s Fair Share Health Care Fund of 2006.

- ²⁶ California's Health Insurance Act of 2003 excluded firms with fewer than 50 workers and dependents in firms with fewer than 200 workers. Because of these exclusions, it is estimated that only 26% of the uninsured would have been covered under this proposal (see Institute for Health Policy Solutions and RAND, March 2005, *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario*). This law was repealed in November 2004 largely because of opposition from the business community.
- ²⁷ These include California's Universal Health Care Act of 2005 and Massachusetts' Health Care Reform Act of 2006.
- ²⁸ Holahan J, LJ Blumberg, A Weil, L Clemans-Cope, M Buettgens, F Blavin, S Zuckerman. October 2005. *Roadmap to Coverage: Synthesis of Findings*. Urban Institute for the Blue Cross Blue Shield of Massachusetts Foundation.
- ²⁹ For a description of the Massachusetts Health Reform Act of 2006 see McDonough JE, B Rosman, F Phelps, and M Shannon, *The Third Wave of Massachusetts Health Care Access Reform*, and Holahan J and L Blumberg, *Massachusetts Health Care Reform: A Look at the Issues*, *Health Affairs*, September 2006.
- ³⁰ Assuming an average wage of \$40,000, an 8% payroll tax would be \$3,200 per full-time worker (see page 14 for a detailed description of the pay-or-play policy change). The Creating Consensus proposal (see note 31) assessed employers \$1 per hour, or about \$2,000 annually per full-time worker.
- ³¹ The Creating Consensus proposal was developed by Davis and Schoen, and incorporated in a number of presidential candidates' health reform proposals in 2004. Davis K and C Schoen. *Creating Consensus on Coverage Choices*. *Health Affairs (Millwood)* [web exclusive], April 23, 2003. Available online at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.199v1> (accessed December 13, 2006); Collins SR, K Davis, JM Lambrew. *Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates' Proposals*. The Commonwealth Fund. Updated October 2004.
- ³² Experience in four states with expansion programs that used sliding-scale premiums indicates that higher out-of-pocket premium shares were associated with lower participation rates (see Ku L and TA Coughlin, 1999, *Sliding-Scale Premium Health Insurance Programs: Four State Experiences*, *Inquiry* Winter 36(4):471-80). Conversely, other research has shown that uninsured rates increase as the cost of health insurance consumes a larger percent of income (see Gilmer T and R Kronick, *It's the Premiums, Stupid: Projections of the Uninsured Through 2013*, *Health Affairs* [web exclusive], April 5, 2005, available online at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Gilmer&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> [accessed December 13, 2006]). Experience in several innovative smaller-scale, private-sector initiatives in New York—designed to target uninsured workers in small firms, the self-employed, and sole proprietors—indicates the challenges of enrolling large numbers of low-to-moderate-income uninsured persons into reduced-cost coverage. These programs have included Brooklyn Health Works, Health for All of Western New York, Small Business Health Insurance program, and Working Today.
- ³³ See also Bobbjerg RR, S Dorn, J Hadley, J Holahan, DM Miller; October 2006, *Caring for the Uninsured in New York: What Does it Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?* Urban Institute; Birnbaum M, 2006, *Medicaid Coverage for Adults in New York, 2001-2003: Trends and Policy Implications*, United Hospital Fund; Birnbaum M, K Haslanger, J Billings, T Mijanovic, E Shapiro, 2004, *Estimating the Cost of Enrolling New York City's Eligible but Uninsured Adults in Medicaid*, United Hospital Fund.
- ³⁴ Bobbjerg RR, S Dorn, J Hadley, J Holahan, DM Miller. October 2006. *Caring for the Uninsured in New York: What Does it Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?* Urban Institute.
- ³⁵ Ibid.
- ³⁶ For example, Minnesota and Wisconsin have expanded Medicaid/SCHIP coverage to parents up to 200% and 185% FPL, respectively, with premium requirements that are similar to those in the proposed FHP buy-in (Center on Budget and Policy Priorities and Centers for Medicare & Medicaid Services. 2006).
- ³⁷ The Bush administration has proposed a national program of tax credits to help the uninsured purchase private health insurance, including through state-sponsored purchasing groups (see U.S. Department of the Treasury, February 2006, *General Explanations of the Administration's Fiscal Year 2007 Revenue Proposals*).