

Final Report:

**Achieving Quality, Affordable Health Insurance for All New Yorkers:
An Analysis of Reform Options**

**Prepared for the New York State Department of Health and
the New York State Department of Insurance**

July 17, 2009

Co-Principal Investigators:

**Linda J. Blumberg
A. Bowen Garrett**

Project Staff:

**Matthew Buettgens
Lisa Clemans-Cope
John Holahan
Aaron Lucas
Paul Masi
Baoping Shang**

The views expressed are those of the authors, and should not be attributed to the Urban Institute, its trustees, or its funders. The authors wish to thank Irene Headen for her valuable research assistance and the staff of the New York State Departments of Health and Insurance for their support and assistance.

Contract number: #C-022780

* Indicates revisions made on 7/30/09 to correct a computation error. See pages 32 and 122 of the narrative and page 69 (Table 2D, column 1-18, lines g and h) of the summary tables.

Table of Contents

Executive Summary	i
Section 1. Introduction.....	1
Section 2. Overview of HIPSM and Issues Related to Provider Supply Constraints	6
The Health Insurance Policy Simulation Model (HIPSM).....	6
Estimates of Anticipated Capacity Constraints Among Providers.	7
Section 3. Detailed Descriptions of Policy Options Modeled	8
Public-Private Hybrid Approaches.	9
Public Health Insurance for All	18
New York Health Plus Plan	19
Modified “Freedom Plan” Approach.....	21
Section 4. Results.....	23
Overview.....	23
Public/Private Hybrid Approaches	28
Public Health Insurance for All	33
New York Health Plus Plan	33
Modified “Freedom Plan” Approach.....	34
Section 5. 5 and 10 Year Results for Models 1-3, 1-17, 2-1 and 3-1	36
Section 6. Responses to Criteria Specified in the Request for Proposal (RFP).....	43
Section 7. Discussion.....	46
Public/Private Hybrid Approaches	46
Public Health Insurance for All	52
New York Health Plus Plan	53
Modified “Freedom Plan” Approach.....	54
Summary Tables	55
Appendix 1. The Health Insurance Policy Simulation Model for New York.....	76
Appendix 2. Cost Containment Strategies and Modeling Assumptions.....	85
Appendix 3. Delivery System Capacity Constraints and Modeling Methodology.....	101
Appendix 4. Full Modeling Results	107

Executive Summary

Achieving Quality, Affordable Health Insurance for All in New York: An Analysis of Reform Options

New York's recent governors made state health care reform a high priority. The administrations assembled internal working groups, held a series of town hall meetings on the topic, and issued a request for proposals for analysis of health care reform options, contracting with and working closely with The Urban Institute's Health Policy Center to perform that analysis. This report reflects the work product produced under those auspices. Support for health care reform has also come from members of the New York State Legislature, and analyses of some of the proposals generated by them are included in the report as well.

We estimate that 2.7 million New Yorkers are uninsured in 2009. Most of the uninsured come from working families and have low incomes (less than 200 percent of the federal poverty level (FPL)). While employer-sponsored insurance (ESI) coverage is the dominant form of coverage for employees, almost one-third of employees do not have ESI. Small group coverage in New York is guaranteed issue and community rated. Non-group coverage is guaranteed issue, community rated, offers a standardized benefit package, has a modest amount of state-funded reinsurance, and has a very small, high-cost enrollee population. A small but meaningful population of New Yorkers are enrolled in the "Healthy New York" program. New York's commitment to public coverage has made the state's uninsurance rate among the low-income population more than 6 percentage points lower than the national average.

The incentives to address the problem of the uninsured are strong. The health and financial implications of going without insurance coverage are serious. In addition, a large uninsured population leads to inappropriate use of certain types of health care services and puts financial strains on the overall health care delivery system. The recent economic downturn serves to increase these pressures. As public program costs increase, and demand for public support for safety net hospitals providing care to a larger uninsured population increases as well, financial pressures mount on state and local governments.

As a consequence, the State is considering an array of health care reform options. These options can be organized in four categories:

- *Public/Private hybrid approaches:* These types of reform are characterized by modest public program expansions coupled with subsidies for the purchase of private coverage and other regulatory reforms. These reforms may include an individual requirement to obtain coverage and they may include employer contribution requirements to the financing of health care.
- *Public Health Insurance for All:* This reform would expand coverage to all New York State residents by creating a new public health insurance program in which

all state residents would be enrolled. The only exception would be those eligible for Medicaid/CHIP, as their coverage would be obtained through those programs which are financed jointly by the state and the federal government.

- *New York Health Plus plan:* Family Health Plus coverage would be made available to all state residents, while retaining some private coverage options. A competing publicly run fee-for-service option, like traditional Medicare, is also available. An employer assessment would contribute to the funding of the plan. Physicians would also be permitted to collectively negotiate payment rates with health plans and the state.
- *Modified “Freedom Plan” approach:* This type of reform would encourage cost savings and increased coverage through enrollment in high deductible private insurance plans and partial subsidization of private coverage through tax credits.

The cost and coverage implications of state reform options falling into these four categories are presented in this report. The request for proposals that the Urban Institute responded to included multiple criteria for analysis which are fully detailed in Section 6. Each specific reform was modeled using The Urban Institute’s Health Insurance Policy Simulation Model (HIPSM).

Each reform approach has different distributional implications for government, employers, and individuals. Providing meaningful coverage to the uninsured would bring significant health, economic, and social benefits; however, broad based system reform will necessitate the state making difficult tradeoffs as the objectives of different stakeholders are balanced.

Each component of a reform’s design carries trade-offs with regard to private versus public costs. For example, the greater the subsidization of coverage, the greater the level of government funding required, but the greater will be the savings to households and employers. An individual mandate ensures that the whole population will be insured, but imposes costs on some who would prefer to remain uninsured. The following are our key findings. Estimates are presented in 2009 dollars.

Public/Private Hybrid Approach—A Combination of Building Blocks:

Public expansions for at least the lowest income adults can cover significant numbers of uninsured New Yorkers at a relatively low cost.

Expansions of current public programs are a fundamental component of all but one of the reform approaches simulated here. These expansions (coupled with the recently implemented expansion for children up to 400 percent of the FPL) are well-targeted strategies that alone lead to significant expansions of insurance coverage (covering 13 to 20 percent of the uninsured), while providing comprehensive coverage to those least able to affordably access care through the private insurance system. New government costs for the expansions analyzed ranged from \$1.5 to \$2.3 billion, and

resulted in employer and individual savings. Limiting public program expansions to those adults below 200 percent of the federal poverty level means that the vast majority of new Medicaid/CHIP enrollees were previously uninsured. In other words, displacement of private insurance coverage is low, and the impact on employer offers is very small.

A merge of the non-group and small group (firms up to 50 employees) insurance markets would significantly reduce premiums associated with non-group coverage while increasing small group premiums somewhat.

The dynamics of that change, however, are significantly affected by interactions with the public program expansion for adults, as discussed later in the report. Adding a merge of the non-group market with the less-than-50-employee small group market increases coverage by over 74,000 people relative to the public expansion alone. This is the case because more individuals voluntarily buy coverage in the non-group market. The cost per newly insured falls relative to the public expansion alone, because the merge increases the take-up of private, unsubsidized insurance. Individual spending increases as more people buy private insurance.

Introducing income related subsidies for the voluntary purchase of private insurance plans in a purchasing pool would cover another one-third of the uninsured population.

Depending upon the level of the subsidies, 28 to 36 percent of the uninsured would be covered under a voluntary approach that is combined with the public expansion and the merge of non-group and small group markets. This approach would result in 50 to 70 percent (depending upon the subsidy schedule) of formerly uninsured subsidy eligible individuals voluntarily taking up coverage. This voluntary expansion of coverage with a public expansion, income related subsidies, and a purchasing pool would cost \$4.3 to \$8.1 billion in government spending, depending upon the subsidy schedule.

An individual mandate, along with income related subsidies and other reforms, reduces the government cost per newly insured person; that is, the incremental cost of the mandate is relatively low.

Many of those enrolling in coverage only under a mandate are healthier and would receive only partial or no government subsidies, making them less expensive to the public sector when enrolled. Private spending increases, however, both for individuals and employers. Once everyone is required to have health insurance of some type, more people will decide that their best coverage option is through their employers. Offers of employer sponsored insurance thus increase relative to the voluntary approach, as more employees choose to trade off wages for employer health insurance benefits. While an individual mandate clearly brings efficiencies in this respect, the tradeoff is that individuals lose some personal choice in how they allocate their resources between health insurance and other goods and services.

Employer spending increases when an individual mandate is added on to an employer pay-or-play mandate.

Under an individual mandate, those who may have had employer offers but not taken them will be very likely to enroll in that coverage. As a consequence, employer spending will rise compared to the same type of reform without an individual mandate. Under all the pay-or-play mandate approaches, however, the biggest increases in employer costs are borne by those employers that did not previously provide health insurance to their employees.

Introducing a public plan option into the purchasing pool is estimated to save both government subsidies and private spending through increased market competition and reduced administrative costs.

This occurs because of lower provider payment rates and administrative costs in the public plan; moreover competition from the public plan is assumed to lower private plan costs. The savings should increase over time as the public plan gains market share and brings its buying power into negotiations over payment rates with providers.

Public Health Insurance for All:

A plan that eliminates private insurance markets in the state and automatically enrolls all residents of the state into a comprehensive public insurance plan would result in a large redistribution of health care financing resources.

The state's entire health care system would be funded through government spending. Total government health care spending would increase by \$57.7 billion. Employer spending on health care would be eliminated, saving employers \$33.3 billion in aggregate. Individuals would save \$22.0 billion in total, with \$11.8 billion in savings accruing to those who spend the most on health care today, those over 400 percent of the FPL.

Public Health Insurance for All would result in a significantly smaller addition to health system spending than Individual Mandate approaches that achieve coverage for all largely through a subsidized private insurance market.

The aggregate change in health system spending under this reform is an additional \$2.4 billion dollars. Savings as a consequence of the lower payment rates to providers and lower administrative costs that would be achieved through a fully government sponsored program are what permit a substantial increase in coverage with a smaller net increase in overall spending.

Public Health Insurance for All would result in some provider capacity constraints.

We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services under the Public Health Insurance for All plan, at

least in the near term, in the amount of \$402 million. The shortfall in supply of medical services relative to demand is the consequence of providing first dollar comprehensive health insurance coverage to all residents. The unmet demand lowers the health care spending from the estimates provided in this report. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

New York Health Plus Plan:

A plan with a large payroll tax assessment on non-offering employers that expands public program eligibility to all individuals, regardless of income, will result in somewhat less redistribution of health care financing than if the public insurance plan is the only system.

This plan is expected to eliminate uninsurance in the state, due to aggressive auto-enrollment efforts. The current non-group insurance market would be eliminated. Employer sponsored insurance would decline by 6.2 million people (almost a 60 percent reduction), as individuals move into Family Health Plus plans. Family Health Plus would enroll 7.4 million people, and an additional 1.7 million would enroll in Medicaid.

This plan would increase government costs by \$33.9 billion (net of the employer assessment revenue of \$13.6 billion) but would save employers and individuals \$9.9 billion and \$17.9 billion respectively, owing to the large scale shift from private to public coverage. Employer based insurance premiums fall significantly for both small and large employers as higher than average cost individuals move from employer coverage to the new public plan.

The New York Health Plus Plan would result in higher health system spending and higher provider capacity constraints compared to the Public Health Insurance for All approach.

The aggregate change in health system spending under this approach would be \$6.1 billion. This program cannot achieve the same level of payment rate savings as Public Health Insurance for All due to the ability of providers to collectively negotiate in the New York Health Plus plan.

We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services, at least in the near term, in the amount of \$1.0 billion. This is higher than the amount of unmet demand under the Public Health Insurance for All Plan because the price per unit of service is higher. However, the speed with which supply expands in the long run under New York Health Plus may also be faster as a result. This unmet demand would lower the health care spending from the estimates provided in this report.

Modified “Freedom Plan” Approach:

The modified “Freedom Plan” approach has the least impact on insurance coverage and, as a consequence, has the smallest total government outlays of the reforms we modeled.

With modest premium subsidies for small employers and individual purchasers, the biggest impact of this plan comes from introducing flexibility in setting premiums—resulting in variation by age and health-status—and high-deductible coverage options in the non-group insurance market. While the number of uninsured decreases by only 15 percent (with most of that attributable to the already implemented public expansion for children), comprehensive coverage in the non-group market is all but eradicated by the introduction of high-deductible plans. While the coverage impact of this approach is very small, the government cost per newly insured is significantly higher than all of the other voluntary reforms, with the exception of the two using the schedule with the higher subsidy level.

Section 1. Introduction

New York's recent governors have made state health care reform a high priority. State-of-the-State addresses by both Governor Spitzer and Governor Paterson have emphasized the need for quality, affordable health coverage for all residents, recognizing that fundamental reforms would be required to expand coverage to the millions of uninsured New Yorkers.¹ These administrations assembled internal working groups, held a series of town hall meetings on the topic, and issued a request for proposals (RFP) for analysis of health care reform options, contracting with and working closely with The Urban Institute's Health Policy Center to perform that analysis. The RFP specified the approaches to be analyzed and included multiple criteria for analysis which are fully detailed in Section 6. Analysis of each proposal was required to include: its cost to government, employers and consumers; the extent to which it reduces barriers to coverage and advances the goal of universal coverage; the impact on the business community; the impact on the provider community; and the impact on scope of benefits, quality of care and consumer choice. This report reflects the work product produced under those auspices.

Support for health care reform at the state level has also come from members of the Legislature. For example, Assembly Member Richard Gottfried² has introduced his own reform proposal, as has a group of legislators.³

¹ New York Governor Eliot Spitzer, State of the State Address, delivered January 3, 2007, <http://www.ny.gov/governor/press/0103073.html>, accessed March 23, 2009 and Governor David Paterson, State of the State Address, delivered January 7, 2009, available at: <http://www.ins.state.ny.us/press/2009/p0901071.htm>, accessed March 23, 2009.

² Assembly Member Richard Gottfried, newsletter on health, spring 2008, available at: http://assembly.state.ny.us/member_files/075/20080527/, accessed March 23, 2009.

³ New York State Assembly, text of bill A.2197, available at: <http://assembly.state.ny.us/leg/?bn=A02197&sh=t>, accessed March 23, 2009.

New York has a number of advantages relative to other states in pursuing state-based reforms. The rate of uninsurance among the non-elderly population (less than 65 years of age) is modestly below the national average – 15.4 percent in New York compared to 17.5 percent in the nation as a whole.⁴ While the overall uninsurance rate in New York is only about 2 percentage points below the national rate, its strong commitment to public coverage has made the state’s uninsurance rate among the low-income population more than 6 percentage points lower than the national average. Nineteen and a half percent of the state’s non-elderly are covered by Medicaid or the Children’s Health Insurance Program (CHIP).⁵

Yet, as is true across the country, rising health care costs in New York have put increasing financial pressure on the privately insured and state budgets. Per capita personal health care spending in New York, across all payers, was \$6,535 in 2004, the most recent year available.⁶ This spending level places New York among the five highest health care spending states in the country.

According to a report by the United Hospital Fund and the Urban Institute, in 2006, 2.4 million people in New York State under age 65 lacked health insurance.⁷ Most of the uninsured come from working families and have low incomes (less than 200 percent of the federal poverty level). New York State’s uninsured are largely working

⁴ John Holahan and Allison Cook, “The Uninsured: A Primer,” report prepared for the Kaiser Family Foundation, October 2008, available at <http://www.kff.org/uninsured/upload/7451-04.pdf>, accessed March 23, 2009. The data used to generate the report referenced here were from a different year and the analysts made different adjustments to it than did the analysts constructing the HIPSM-NY model used for simulating the effects of health care reform in New York State and presented later in this report. As a consequence, estimates of the number of uninsured in the state vary somewhat across the sources.

⁵ Only Maine and Vermont at 19.6 percent have higher rates of Medicaid/CHIP coverage than New York.

⁶ US Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), published tables of estimated state personal health expenditures, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-us.pdf>, accessed March 23, 2009.

⁷ Allison Cook, Danielle Holahan, and Aimee Williams, “Health Insurance Coverage in New York, 2005–2006,” United Hospital Fund, http://www.uhfnyc.org/usr_doc/Health_Insurance_Coverage_in_New_York_2005_2006.pdf.

adults or their dependents or individuals from low-income families: nearly two-thirds of the uninsured have family income no greater than 200 percent of the federal poverty level (FPL). Over 80 percent of the uninsured are workers or their dependents. Coverage patterns vary in New York City and in the rest of the state. New York City has a greater share of uninsured people than does the rest of the state. Residents outside New York City are more likely to have employer-sponsored insurance (ESI) and are less likely to have public coverage or to be uninsured. Many uninsured New Yorkers are eligible for existing public health insurance.

While ESI coverage is the dominant form of coverage for employees, almost one-third of employees do not have ESI. Employees without ESI are more likely to be uninsured than enrolled in public coverage or non-group (direct purchase) coverage. Small group coverage in New York is guaranteed issue and community rated. Non-group coverage is guaranteed issue, community rated, offers a standardized benefit package, has a modest amount of state-funded reinsurance, and has a very small, high-cost enrollee population. A small but meaningful population of New Yorkers is enrolled in the “Healthy New York” program—about 155,000 enrollees as of the end of 2008. With eligibility limited to uninsured workers and their families, it is a state sponsored program with standard, streamlined benefit packages and state-funded reinsurance.

The incentives to address the problem of the uninsured are strong. The health and financial implications of going without insurance coverage are serious. Uninsurance has been shown to lower access to care and limit the use of preventive services. The evidence strongly indicates that lack of coverage has adverse effects on the overall population’s health as well. Being uninsured can create major financial burdens for

families and is also a major contributor to personal bankruptcy. In addition a large uninsured population leads to inappropriate use of certain types of health care services and puts financial strains on the health care delivery system.

The recent economic downturn serves to increase these pressures. While the most recent available data are not current enough to measure the impact of the recession, research does indicate that increases in the unemployment rate significantly decrease health insurance coverage.⁸ The largest impact on coverage is for adults, as many children (all those up to 400 percent of the FPL) will be eligible for Medicaid, CHIP or fully state-financed coverage, but public coverage eligibility for adults is much more limited.⁹ As public program costs increase and demand for public support for safety net hospitals providing care to a larger uninsured population increase as well, financial pressures mount on state and local governments. This is occurring at the same time as overall state general revenues are falling due to the recession.¹⁰

As a consequence, New York is considering an array of health care reform options. These options can be categorized in four main groups:

- *Public/Private hybrid approaches*: These types of reform are characterized by modest public program expansions coupled with subsidies for the purchase of private coverage and other regulatory reforms.
- *Public Health Insurance for All*: This reform would expand coverage to all New York State residents by creating a new public health insurance program in which all state residents would be enrolled. The only exception would be those eligible for Medicaid/CHIP, as their coverage would be obtained through those programs which are financed jointly by the state and the federal government.

⁸ John Holahan and A. Bowen Garrett. 2009. "Rising Unemployment, Medicaid and the Uninsured." prepared for the Kaiser Commission on Medicaid and the Uninsured. Accessible at: <http://www.kff.org/uninsured/upload/7850.pdf>.

⁹ Parents of dependent children are eligible up to 150% of the federal poverty level, pregnant women are eligible up to 200% of poverty, and childless adults are eligible up to 100% of poverty.

¹⁰ See for example, Nicholas Confessore and Danny Hakim. 2009. "N.Y. State Leaders Outline Budget Deal," *New York Times*, March 29, 2009.

- *New York Health Plus plan*: Family Health Plus coverage would be made available to all state residents, while retaining some private coverage options. An employer assessment would contribute to the funding of the plan. Physicians would also be permitted to collectively negotiate payment rates with health plans and the state.
- *Modified “Freedom Plan” approach*: This type of reform would encourage cost savings and increased coverage through enrollment in high deductible private insurance plans and partial subsidization of private coverage through tax credits.

The cost and coverage implications of an array of state reform options falling into these four categories are presented in this report. Each specific reform was modeled using The Urban Institute’s Health Insurance Policy Simulation Model (HIPSM). Section 2 provides a brief overview of HIPSM and a discussion of potential supply-side constraints under reform. A more detailed methodological description of HIPSM and the supply-side constraints can be found in Appendices 1 and 3, respectively. Section 3 provides detailed descriptions of the policy options modeled. Section 4 provides single year simulation results for several policy options. A detailed description of the simulation results for each policy option can be found in Appendix 4. Section 5 provides simulation results for four policy options 5 and 10 years post implementation. Section 6 delineates how the report responded to the criteria specified in the state’s original request for proposals (RFP). Section 7 provides a concluding discussion of the results. Appendix 2 provides a description of cost containment options that could be applied to any of the approaches presented, thereby reducing the costs of implementation relative to what is presented in this report.

Section 2. Overview of HIPSM and Issues Related to Provider Supply Constraints

The Health Insurance Policy Simulation Model (HIPSM).

For each reform, we provide HIPSM results for the estimated impact on health insurance coverage by type (employer-based coverage, directly purchased/non-group coverage, public coverage (Medicaid/CHIP), and the uninsured); the rate at which employers offer health insurance coverage to their workers; government, employer, and household costs; and health insurance premiums. The impacts of reforms on household spending are shown in aggregate and for three income groups: those with incomes below 200 percent of the federal poverty level (FPL), those between 200 and 400 percent of the FPL, and those with incomes above 400 percent of the FPL. Government spending levels include both federal and state costs. Increased costs falling under the Medicaid and CHIP would be shared by the state and the federal government; costs associated with new subsidized insurance programs would most likely be the state's responsibility to finance.

To predict the effects of health insurance reform options in New York State, we used a New York-specific version of the Health Insurance Policy Simulation Model (HIPSM-NY), developed by researchers in the Urban Institute's Health Policy Center. This microsimulation model provides estimates of the effects of alternative proposals to expand health insurance coverage relative to current law in the state. For each of the proposed reforms, HIPSM-NY provides estimated changes in health insurance coverage and premiums, changes in costs for government, employers and individuals, changes in the share of employees receiving an offer of ESI, and many other results. A description of the construction and workings of HIPSM-NY is provided in the appendix to this report.

Estimates of Anticipated Capacity Constraints Among Providers.

Ultimately, the ability of health care reform to increase access to health care in New York State does not only depend on its ability to expand coverage—it also depends on health care providers and the supply of services. Overall, we estimate that the health care delivery system would encounter significant additional capacity constraints in reforms which provide coverage to all New Yorkers through first-dollar coverage or other coverage with nominal cost sharing, such as in the Family Health Plus (FHP) benefit package. Thus, the health care spending results for the Public Health Insurance for All (Model 2-1) and the New York Health Plus plan proposed by Assembly Member Gottfried (Model 3-1) presented in Section 4 take into account these constraints, since each involves first-dollar, or nearly first-dollar, coverage for a substantial share, if not all, of state residents.

We estimate that approximately 83 percent of the increase in health expenditures due to first-dollar coverage for New Yorkers could be met given existing PCP and hospital capacity. We find that reforms which provide coverage to all through a combination of private and public plans have minimal overall capacity constraints beyond the supply constraints already in the system. For these reforms, the amount of anticipated new spending that will *not* be met due to existing capacity constraints is shown at the bottom of the spending tables. Appendix 3 describes the methodology used to calculate these supply constraints.

Section 3. Detailed Descriptions of Policy Options Modeled

This section describes the specific components of the four main policy options modeled—the public/private hybrid approach, Public Health Insurance for All, New York Health Plus plan, and the modified “Freedom Plan” approach—and specific assumptions made about the plans with regard to their cost containment and coverage potential. All reform options were simulated in 2009 with expenditures presented in 2009 dollars, as if the reforms had been implemented and in place for 3 years.¹¹ Under this time framework, we assume that individual and employer behavior are fully realized. Any cost-savings specifically associated with a particular reform may only be partially realized, however. For example, if the full impact of a certain cost containment strategy is expected to take 10 years to achieve fully, the 2009 estimates include only about a third of the complete cost savings potential. This approach allows us to make comparisons across approaches on an even basis, without understating the cost implications of reforms in the early years. In the subsequent section, we discuss the simulation results of several key reform options simulated; the results of the remaining options are described in Appendix 4.

In addition to being able to compare many models in a one-year snapshot framework, there is value in having some insight into how reform costs and coverage are expected to evolve over 10 years post-implementation. As a result, cost and coverage results for four approaches will be shown as the reforms would appear in implementation years 5 (i.e., 2014), and 10 (i.e., 2019). Health care cost, income, and population growth are taken into account across the 10 year period.

¹¹ Due to the timing of the analysis done here, the core results presented for 2009 do not take the effects of the recent economic downturn into account.

Public-Private Hybrid Approaches.

The public-private hybrid approaches simulated for this report build upon each other using common elements. While multiple options within a type of reform element were modeled, one option is chosen in each category to follow through to the next grouping, in order to focus on the reforms of greatest interest. All options focus on the non-elderly population of New York State. This group of approaches lends itself to many possible variants. While infinite alternatives are possible, we limited them to what we considered a manageable number that would provide a range of options.

The first simulations are reforms limited to expansions of the existing Medicaid/CHIP public insurance programs in New York. While these simulations involve changes to public programs alone, we include them in the public-private hybrid category as they are building blocks for the hybrid approaches that follow.

Public Program Expansions.

All options presented in this report include an expansion of the state's Medicaid/CHIP programs for the lowest income population. Current law includes CHIP eligibility for children in families up to 400 percent of the federal poverty level (FPL). However, the most recent available data on health insurance coverage in New York pre-dates this expansion, so the cost and coverage implications of the expansion for children are included in each model as part of the policy simulation. In addition, as stand-alone models, we simulated the expansion of public insurance in New York to:

Model 1-1: all adults in families with incomes up to 160 percent of the FPL;

Model 1-2: all adults in families with incomes up to 200 percent of the FPL.

The rationale behind a public program expansion for adults is that Medicaid has the most experience in providing for the special needs of the lowest income population, many of whom have higher than average health care needs, need language assistance, transportation assistance, and are unable to contribute substantially to the cost of their coverage, either through premiums or out-of-pocket cost-sharing. As a result, they are likely to require broader health care benefits and additional services than the general population.

Model 1-2 was chosen as the basis of subsequent modeling runs for the public-private hybrid approaches. For each of these options, and for all subsequent simulations that include one of them, we assume that an increased investment is made in outreach and enrollment/retention simplification. Based on a review of the evidence by Donna Cohen Ross of the Center on Budget and Policy Priorities and the Lewin Group, both of whom reviewed several studies, we concluded that such strategies would increase public program participation by 15 percent within 3 years of reform implementation. The simplifications include: self-certification of income, express lane eligibility, elimination of asset tests, and biennial review with annual postcard renewal. This increased participation is reflected in the main results tables.

Merge of the Private Non-Group and Small Group Insurance Markets.

This set of reforms would require private insurance carriers to offer identical coverage at community rated premiums to all those seeking to purchase coverage either as individuals or through small employers (firms up to 50 employees). In other words, premiums for the same coverage in the group and non-group insurance markets would be identical. The rationale is to spread the health care risk more broadly across both of these

markets, significantly decreasing the premiums for individual purchasers with small increases for small group purchasers. All the options simulated included the Model 1-2 expansion of public insurance to adults up to 200 percent of the FPL and children up to 400 percent of the FPL, as well. The first set of options including the proposed merge of the non-group market and the small group market are modeled as follows:

Model 1-3: Model 1-2 plus merge of the non-group market and small group market for firms up to 50 employees;

Model 1-4: Model 1-2 plus merge of the non-group market and small group market for firms up to 100 employees;

Model 1-5: Model 1-3 plus government funded reinsurance to compensate small employer purchasers for any adverse premium impact resulting from the merge of the non-group and small group markets;

Model 1-6: Model 1-3 plus a payroll assessment on employers of 50 or more employees. The payroll assessment liability can be offset dollar for dollar by the amount an employer contributes to its employees' health insurance. The size of the payroll assessment varies with each employee's wage, such that lower assessments are imposed on low-wage employees, higher assessments imposed on higher-wage employees.¹²

Under Model 1-6, no new purchasing entity or subsidies are made available to assist employees without employer offers in their purchase of individual insurance coverage.

The payroll assessment is used as a mechanism to help finance the public program

expansion. Model 1-3 was selected as the basis of subsequent simulations.¹³

¹² The payroll assessment schedule is as follows: 2 percent when wages are less than \$20,000; 4 percent when wages are between \$20,000 and \$60,000; and 6 percent when wages are greater than \$60,000.

¹³ Private insurance plan modeling is based upon a standardized benefit package and does not explicitly model competing varying benefit package options. The standardized package includes a deductible of \$400 for single coverage \$800 for family, co-insurance of 20% after the deductible, and out-of-pocket maximums of \$1990 and \$3980 for single/family coverage, respectively.

New Purchasing Pool with Subsidies Offered to Make Coverage Affordable to the Modest Income Population.

A new purchasing pool would be developed that would contract with private plans to provide coverage to individuals and small employers (defined here as having fewer than 50 employees). All of those buying coverage as individuals or via small employers would do so through the pool. Medicaid/CHIP eligible adults and children remain eligible for public insurance but are ineligible for subsidies within the purchasing pool under this set of options, so as to maximize the federal dollars available to support state coverage expansions.¹⁴ Two subsidy schedules were laid out, and subsidies were made available up to varying levels of family income under different simulations. These are premium subsidies and do not apply to out-of-pocket costs associated with coverage, although those obtaining coverage through the public program expansions would not have out-of-pocket requirements. The full schedules are:

¹⁴ An exception to this rule is made for families with mixed eligibility (i.e., some members eligible for public insurance and some ineligible for public insurance). These families are eligible for subsidies within the purchasing pool.

Subsidy Schedule A		Subsidy Schedule B	
Family Income Relative to the Federal Poverty Level (FPL)	Maximum percentage of family income an individual or family would pay for premiums	Family Income Relative to the Federal Poverty Level (FPL)	Maximum percentage of family income an individual or family would pay for premiums
Below 200%	No cost – coverage through public program expansion	Below 200%	No cost – coverage through public program expansion
200 – 249%	6%	200 – 224%	Individuals 1.4% Families 1.6%
250 – 299%	8%	225 – 249%	Individuals 1.6% Families 2 %
300 – 349%	10%	250 – 299%	Individuals 2.4% Families 2.9%
350 – 399%	12%	300 – 349%	Individuals 2.8% Families 3.4%
		350 – 399%	Individuals 3.5% Families 4.1%
		400 – 499%	Individuals 4.3% Families 5.1%
		500 – 599%	Individuals 4.7% Families 5.8%

Subsidy Schedule A is based upon an analysis of current levels of spending relative to income by those with full year private health insurance, but recognizing that there is an income level below which individuals and families cannot be expected to make significant contributions toward their health insurance coverage.¹⁵ It is one attempt to strike the difficult balance between the affordability of coverage for individuals and families with the government costs associated with subsidy levels. Schedule A would provide less financial assistance to households than Schedule B. Schedule B would

¹⁵ Linda J. Blumberg, *et al.* 2007. “Setting a Standard of Affordability for Health Insurance Coverage.” *Health Affairs*. July/August, vol. 26(4): w463-w473.

provide significantly lower cost coverage to households than Schedule A, but at higher cost to the government. Insurance coverage remains voluntary under all the options. The options modeled are as follows:

Model 1-7: Model 1-3 plus purchasing pool, and Subsidy Schedule A for those up to 300 percent of the FPL;

Model 1-8: Model 1-3 plus purchasing pool, and Subsidy Schedule A for those up to 400 percent of the FPL;

Model 1-9: Model 1-3 plus purchasing pool, and Subsidy Schedule B for those up to 400 percent of the FPL;

Model 1-10: Model 1-3 plus purchasing pool, and Subsidy Schedule B for those up to 600 percent of the FPL.

Model 1-8 was selected as the basis for subsequent simulations.

Individual and Employer Mandates.

Individual mandates are requirements that individuals enroll in health insurance coverage meeting minimum standards defined by the state. Public coverage, employer based insurance, or non-group insurance could all satisfy such a requirement. Short of a single payer government system approach, an individual mandate is necessary to achieving coverage for all. Without an individual mandate, some workers will opt not to take-up offers of coverage by their employers and some will choose not to enroll in coverage as individuals.¹⁶

Coverage offered within the purchasing pool would be designed to meet the state's minimum standards, and existing public coverage would do so as well. While ERISA prohibits states from defining benefits offered by employers, employer plans would in all likelihood comply with minimum requirements set by the state. This is the

¹⁶ Linda J. Blumberg and John Holahan. 2008. "Do Individual Mandates Matter?" Timely Analysis of Immediate Health Policy Issues, The Urban Institute. Available at http://www.urban.org/UploadedPDF/411603_individual_mandates.pdf.

case because employer-based coverage already tends to be relatively comprehensive, and for the small percentage that are not, employers would be likely to modify their plans into compliance. Employers would do this so that their coverage would satisfy their employees' demands for coverage that meets the requirements of the individual mandate.

The chief enforcement mechanism of the individual mandate would be the state tax system. Individuals would receive annual documentation from their insurer that would be included with state tax returns, verifying the number of months they had been covered by insurance in the preceding year. Those who were not enrolled in coverage at tax time would be automatically enrolled in coverage through the purchasing pool (and notified of an opportunity to change their plan), and be subject to a tax penalty in addition to premium contribution requirements.¹⁷ However, the main focus of the individual mandate will be on voluntary compliance – making it easy and attractive for individuals to enroll voluntarily. Providing many outlets for enrollment – both physical locations with well-trained assistants, internet-based enrollment, school-based auto-enrollment for uninsured children, employer-assisted enrollment even through employers not making contributions to coverage, and provider-based enrollment when coverage is sought would ensure the achievement of a fully insured population.

Model 1-11: Model 1-8 plus an individual mandate on all adults and children.

Employer pay-or-play mandates require employers to pay an assessment, or tax if they choose not to offer health insurance coverage to their employees. This tax liability can be offset dollar-for-dollar by the amount an employer spends on health care

¹⁷ Those automatically enrolled in this way may be eligible for subsidized coverage, depending upon their income. Low-income individuals who would have been eligible for subsidized insurance coverage had they enrolled at the appropriate time would be subject to no or lower penalties than higher income non-participants.

premiums for their employees. Such assessments can be designed in a multitude of ways and may even exempt some employers. The approach taken here is to use the same payroll assessment schedule used in Model 1-6, which varies with the individual employee's wage level. The revenue from the assessment is then used to help finance the costs of the coverage expansion. A number of small firm exemptions were modeled. The following employer pay-or-play options do not include an individual mandate and are modeled as follows:

Model 1-12: Model 1-8 plus an employer pay-or-play mandate on all employers (no exemptions). The employer assessment varies with each employee's wages and can be offset by employer spending on premiums;

Model 1-13: Model 1-8 plus an employer pay-or-play mandate on employers of 10 or more employees. The employer assessment varies with each employee's wages and can be offset by employer spending on premiums;

Model 1-14: Model 1-8 plus an employer pay-or-play mandate on employers of 25 or more employees. The employer assessment varies with each employee's wages and can be offset by employer spending on premiums;

Model 1-15: Model 1-8 plus an employer pay-or-play mandate on employers of 50 or more employees. The employer assessment varies with each employee's wages and can be offset by employer spending on premiums.

The final three public-private hybrid models presented here add an individual mandate to an employer mandate, one without a small firm exemption and two with an exemption. Under Model 1-18, a state self-funded health insurance plan is introduced as one insurance plan option within the purchasing pool. The state self-funded health plan modeled here is consistent with the description of a public health insurance plan option

provided elsewhere.¹⁸ The new option would operate similarly to the traditional Medicare program, in that it would adopt Medicare payment rules, paying between current Medicare rates and private insurer payment rates. The new state plan would be responsible for claims payment, utilization review, development of disease management and chronic care coordination programs and would offer the same benefits as the private insurers within the new purchasing pool. The objective of introducing such a plan is to catalyze competition in the private insurance market, using the power of a strong buyer to bring down provider payment rates.

Model 1-16: Model 1-12 plus an individual mandate;

Model 1-17: Model 1-13 plus an individual mandate;

Model 1-18: Model 1-17 with a public insurance plan option offered within the purchasing pool.

The modeling presented assumes that the public plan option could achieve 10 percent savings off of expected health care costs for its enrollees by 10 years post-reform. We also assume that competition from the public plan would provide strong incentives for the private plans to reduce costs as well, leading to 5 percent savings for enrollees under those plans by 10 years post-reform. One-third of these long run savings estimates are assumed to be achieved by year 3 of reform implementation, and are reflected in the main results tables.

¹⁸ See for example, John Holahan and Linda J. Blumberg. 2008. "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform." The Urban Institute Health Policy Center Issue Brief. Available at: http://www.urban.org/UploadedPDF/411762_public_insurance.pdf; and John Holahan and Linda J. Blumberg. 2009. "Massachusetts Health Reform: Solving the Long-Run Cost Problem." Timely Analysis of Immediate Health Policy Issues, The Urban Institute. Available at: http://www.urban.org/UploadedPDF/411820_mass_health_reform.pdf.

Public Health Insurance for All.

This reform would expand coverage to all New York State residents by creating a public health insurance program available to all and using automatic enrollment techniques to insure that everyone is enrolled. Those currently eligible for Medicaid would be enrolled in that program. In this way, federal matching funds would continue to be available to the maximum extent possible for purposes of financing reforms.

Model 2-1: Public Health Insurance for All: Aside from Medicaid eligibles, all New York State residents would be enrolled in a fully publicly financed first-dollar coverage insurance plan.

Medicaid payment rates are assumed to increase to Medicare levels, as it does not seem feasible for these rates to stay as low as they are once most or all state residents are enrolled in public plans. Under a Medicaid program with higher payment rates, those with public insurance in the baseline may use a more efficient mix of providers under reform, leading to some savings. To accommodate necessary increases in payment rates and savings from use of more efficient providers, we increase spending of existing Medicaid/CHIP enrollees by 18 percent. This adjustment is computed using New York State and national fee schedule data by insurer and expenditure data from the MEPS-HC.¹⁹ The new public plan created under Model 2-1 is assumed to have administrative costs equal to 5 percent of claims paid and is assumed to save 10 percent of health care costs relative to baseline anticipated spending by 10 years post-implementation of the reform.

¹⁹ Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Trends: Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation," Health Affairs Web Exclusive, June 23, 2004. See <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1>; Will Fox and John Pickering, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman, December 2008, p. 5. See <http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf>.

New York Health Plus Plan.

This reform would expand coverage to all New York State residents through a New York Health Plus program available to all, with automatic enrollment techniques to insure that everyone is enrolled. A competing publicly run fee-for-service option, like traditional Medicare, is also available. Private and supplemental health insurance coverage remains. Those currently eligible for Medicaid would be enrolled in Medicaid, so that federal matching funds would continue to be available to the maximum extent possible for purposes of financing reforms. The reform includes assessments on some employers.

Model 3-1: New York Health Plus Plan: Family Health Plus coverage would be made available to all state residents. All employers would be required to pay a payroll tax to contribute to the funding of the plan. The payroll tax liability could be offset dollar-for-dollar for any contributions employers make to providing health insurance for their workers. The payroll tax rate is set at 10 percent and the wages to which the tax applies are not capped.²⁰ Physicians would also be permitted to collectively negotiate payment rates with health plans and the state.

As with Model 2-1, to accommodate necessary increases in payment rates and savings from use of more efficient providers, we increase spending of existing Medicaid/CHIP enrollees by 18 percent, based on computations described above. While the new expanded Family Health Plus plan under Model 3-1 shares the low administrative costs and downward pressure on hospital fees with Model 2-1, it is expected to save only 3 percent of health care costs by 10 years post-reform, as physicians are allowed to collectively negotiate with health plans, a provision that will

²⁰ The New York Health Plus plan did not specify a particular payroll tax assessment level. 10 percent was used for purposes of these estimates given our understanding that the intent was to raise a substantial share of program costs through this mechanism.

tend to increase costs.²¹ Permitted to work together as a bargaining unit, physicians would be in a substantially more powerful position vis a vis insurers in rate negotiations. Insurers would be unable to exert cost containment pressure on providers acting as a unit, since they could always threaten not to participate in a plan at lower rates, leaving the plans with no alternative source of providers.

Public Health Insurance for All (Model 2-1) and New York Health Plus plan (Model 3-1) would provide a large portion of the population with comprehensive insurance coverage with little or no cost sharing. This type of change would increase demand for health care services significantly, and is likely to put pressures on the ability of providers (physicians, hospitals, etc.) to satisfy overall demand. Based upon an analysis of current capacity in the current New York health care system, we have estimated the short term constraints in supply that could be expected as a consequence of these reforms.²² The calculations of supply constraints are described in Appendix 3. While hospitals have greater flexibility in altering capacity, we anticipate that physician supply would be less responsive in the short-term. In addition, the state has little ability to alter physician supply. There is considerable uncertainty surrounding these estimates of supply constraints, however, because it is unknown whether physicians will respond. For example, physicians may increase their hours in response to greater demand or increase their use of ancillary medical professionals significantly. In addition, because we assume that Medicaid payment rates will increase to Medicare levels and the new

²¹ In the new plan, hospital rates are assumed to be held to 10 percent below baseline anticipated spending over 10 years, but physicians are assumed to be 10 percent above baseline rates over the same period due to collective negotiation. Weighting these rates by the shares of hospital versus physician expenses results in net savings of approximately 3 percent over 10 years.

²² The analysis of excess capacity in the current system and the development of an analytic structure for calculating potential supply constraints under reform were done by Sherry Glied of Columbia University.

public programs will pay providers at rates between Medicare and private levels, we do not assume additional supply problems as a consequence of poor reimbursement.

Modified “Freedom Plan” Approach.

Some approaches to reform focus on providing alternative products in the non-group market. The proposed products include plans with premiums that are permitted to vary based on certain characteristics, and with higher levels of cost-sharing (larger deductibles, out-of-pocket maximums, etc.). The introduction of such products is intended to increase coverage through expansion of coverage options and to encourage individuals to be more efficient consumers of medical care. These types of reforms may be accompanied by some subsidies for the purchase of private coverage. The approach modeled here is based upon proposals of this type introduced in the Legislature.

Model 4-1: Modified “Freedom Plan” approach. The introduction of a high deductible policy into the private non-group insurance market; increased flexibility for rating non-group health insurance policies based upon health care risk; an additional \$31 million contributed to the existing government funded reinsurance in the state’s non-group market; subsidies for the purchase of small group and non-group policies.

The new product offered in the private non-group market in this model is structured as follows: deductible of \$2,230, coinsurance of 20 percent, and out-of-pocket maximum of \$3,120 for single policy-holders, and deductible of \$4,460, coinsurance of 20 percent, and out-of-pocket maximum of \$6,240 for family policy-holders.²³ Premium rating in the non-group market is allowed to vary by policy form, as outlined in the proposal.²⁴ Bill number A.2197/S.3092 includes a tax credit subsidy for small businesses and individuals that phases in over 10 years to 50 percent of the cost of health insurance

²³ This policy is Health Savings Account qualifying, but we have not modeled the savings account component here due to current limitations of the simulation model.

²⁴ We believe that this new rating proposal will open the door to significant segmentation of health care risk, substantially undermining the risk pooling inherent in community rating, and we have modeled it as such.

premiums. In the small employer market, the subsidy applies only to the employer's premium contribution, but applies to the full premium in the non-group market. Given that we model all reforms as they would be in the third year of implementation, this implies a 15 percent subsidy, in accordance with the phase-in schedule for the bill. Regardless of whether the individual non-group purchaser chooses a high or low deductible policy, the subsidy is capped at 15 percent of the high deductible plan's premium. All subsidies are refundable, meaning they are not limited by the tax liability of the individual or employer. The bill did not make the employer credit refundable, but, due to modeling limitations, only refundable employer tax credits could be simulated. At this time, we are not able to simulate the effects of changes in income eligibility rules for Healthy New York, which was a component of bill A.2197/S.3092.

Section 4. Results

Overview

In this section, we first present an overview of the results of all reform options simulated. Then, the results for simulations of the four main reform options are described in detail. The main reform options include the public/private hybrid approach (for which we present detailed results for 6 models which incrementally build upon each other), Public Health Insurance for All, New York Health Plus plan, and the Modified “Freedom Plan” approach. To streamline the presentation and discussion of reform options, the detailed results for the remaining public/private hybrid options are described in Appendix

4. We provide results for every reform option in sets of 4 tables:

- health insurance coverage effects are in Tables 1A-1D;
- health care spending effects for government, employers, and individuals are in Tables 2A-2D;²⁵
- effects of reforms on the share of workers who are offered health insurance by their employers are shown in Tables 3A-3D; and
- effects of reforms on employer-sponsored and private non-group insurance premiums are found in Tables 4A-4D.

The “A” tables show results for Models 1-1 through 1-5, the “B” tables show results for Models 1-6 through 1-10, the “C” tables show results for Models 1-11 through 1-15, and the “D” tables show results for Models 1-16 through 4-1, with the models numbered according to their descriptions in Section 3. In this section, we highlight the main findings from the results presented in the tables.

²⁵ The cost tables do not report uncompensated care costs or how they change under the different policy options.

It is important to keep in mind that these results do not include full financing of the health care reforms simulated or the full distributional consequences (i.e., who would bear the costs of whichever financing approach is taken). The only portion of financing presented here is the revenue raised through assessments on employers that were important design components of Models 1-6, 1-12 to 1-18, and 3-1. There are a variety of approaches that could be used to finance the costs of all of the models presented here. Exploring these options is beyond the scope of this report.

Coverage Effects. The two public coverage-centered options, Public Health Insurance for All (Model 2-1) and the New York Health Plus plan (Model 3-1), would both achieve coverage for all in the state. The Public Health Insurance for All approach would automatically enroll all permanent residents into the new program. The New York Health Plus approach would effectively do the same, as all individuals that did not voluntarily enroll in some type of coverage would be automatically enrolled in the new public insurance plan. The public-private hybrid approaches that include an individual mandate (a legal requirement that all individuals enroll in insurance coverage of a minimum level – Models 1-11, 1-16, 1-17, and 1-18) would also achieve coverage for all, assuming aggressive auto-enrollment strategies and significant financial penalties for non-compliance. Those models that include neither public program options covering all residents nor an individual mandate will leave a portion of the population uninsured post-reform. Of the reforms that would *not* achieve coverage for all, Model 1-10 (which introduces the highest level of premium subsidies under a voluntary system where coverage is not mandatory) would increase coverage the most, and Model 1-1 (which

introduces a public program expansion alone) would have the smallest effect on insurance coverage.

Cost Effects. Some redistribution of health care spending is inherent in all health care reforms. The Public Health Insurance for All and the New York Health Plus plan approaches will increase government spending while generating savings to individuals and employers. Public-private hybrid approaches will tend to increase government spending, but less so than the Public Health Insurance for All and the New York Health Plus plan approaches, with government spending increasing with larger premium subsidies. The greater the investment in insurance coverage by the government, the greater is the savings for individuals and employers. To the extent that reforms, such as the modified “Freedom Plan” approach, encourage the purchase of less comprehensive insurance policies, private premium savings will be achieved, but at the cost of higher out-of-pocket costs to those with the greatest health care needs. Likewise in the modified “Freedom Plan” approach that would allow variation in non-group premium prices by policy form, costs will be shifted towards those who are the highest users of medical care while savings will be realized by the healthiest.²⁶

New government costs will be divided between the federal government and the state government. The share of new spending paid by the federal government is uncertain, since it will depend on negotiations between the federal government and the state (e.g., Medicaid waiver). As a consequence of this uncertainty, we do not attempt to divide government costs, and we present them here as total federal and state spending.

²⁶ We believe that rating by policy form would open the door to significant segmentation of health care risk, substantially undermining the risk pooling inherent in community rating, and we have modeled it as such.

Those approaches that achieve coverage for all will tend to increase overall health care spending in the system (including public and private spending) the most, while those with modest impacts on insurance coverage will have smaller effects on system-wide spending.

Employer-Sponsored Insurance Offer Effects. Options that provide large expansions of public programs will decrease the likelihood of employer sponsored insurance offers the most. Proposals that would make public coverage available to all would generally result in large reductions in ESI offers. Those options which make private non-group insurance more attractive than it is today, for example by providing greater subsidies for its purchase, will have the effect of lowering employer-sponsored insurance offers as well, but to a substantially lesser extent. Employer mandates would provide additional incentives for employers to offer coverage. Individual mandates, by boosting demand for ESI among workers, would also lead more employers to offer coverage.

Premium Effects. Premiums in private insurance markets are determined largely by the expected costs of the groups of individuals that enroll in that coverage. Reforms will tend to make certain types of coverage (e.g., employer-sponsored insurance, private non-group insurance, Medicaid/CHIP) more attractive than they are today, while making other types of coverage or remaining uninsured less attractive. Some reforms, such as the modified “Freedom Plan” approach modeled here, will change the rules by which insurers are allowed to set premiums, thereby making certain types of coverage more or less attractive to particular groups of individuals. As individuals and groups change their health insurance coverage decisions, the average health care costs of those in a particular

type of coverage are likely to change as well, leading to changes in private health insurance premiums post-reform.

Increasing access to comprehensive low or no cost public insurance coverage under reform will tend to disproportionately pull individuals with high medical needs out of private insurance pools and into public plans because they would benefit the most from lower cost sharing. This dynamic will tend to lower premiums in the private insurance market. Merging the small group market with the non-group market will decrease premiums in the non-group market substantially, as the high costs associated with current non-group enrollees are spread more broadly. As non-group market premiums fall, lower cost individuals will be attracted into that market.

What follows are the detailed results that show the state's baseline prior to reform and the state impacts of 4 types of reform options simulated. Note, those with Medicare coverage are excluded from all of the statistics presented.

New York State at Baseline. See summary Tables 1A-4A, column 0.

- Currently in New York State, 10.5 million people (61.1 percent of the population) have health insurance coverage through employer-sponsored insurance (ESI). Medicaid/CHIP (which includes Family Health Plus and Children's Health Plus) covers 3.7 million people, or 21.4 percent. About 250,000 or 1.4 percent are covered though the non-group market (including standard and non-standard non-group coverage and coverage through the Healthy New York program). An estimated 2.7 million people in the state are uninsured (15.8 percent).^{27 28 29} [Table 1A, column 0]
- Government spending for Medicaid/CHIP in New York State is approximately \$28.5 billion in acute care coverage for the non-elderly.³⁰ [Table 2A, line a]

²⁷ The Current Population Survey for 2007, which was used for our population targets, showed 2.66 million uninsured in NY for 2006. Adjusted for expected population growth, we obtain 2.71 million uninsured in NY in 2009. Subsequent to creating our baseline file, the 2008 CPS was released, which shows 2.46 million uninsured in 2007.

²⁸ The baseline data include undocumented immigrants, although they are thought to be somewhat underrepresented in the CPS.

²⁹ There are an estimated 178,000 sole proprietors among the uninsured.

³⁰ The \$28.5 billion includes CHIP spending and reflects growth to 2009. It excludes Medicaid spending on the aged and long term care. Average spending per person under Medicaid/CHIP is \$7,703. This is

- Employers in New York State spend approximately \$33.3 billion on employer-sponsored insurance for employees and their dependents. [Table 2A, line i] Individuals spend approximately \$22.0 billion, including health insurance premiums, coinsurance, and deductibles for those with coverage through ESI and the non-group market and including out-of-pocket spending for those who are uninsured as well as insured. [Table 2A, line o]
- Among small firms (fewer than 50 employees at all locations) in New York State, 63.1 percent of employees have an offer of ESI; among large firms (50 or more employees at all locations), 92.0 percent of employees have an offer of ESI. [Table 3A, column 0]
 - Average premiums in the small group employer-sponsored insurance market average \$5,994 for single coverage and \$15,253 for family coverage. Average premiums in the large group market are \$5,240 and \$13,408 for single and family coverage, respectively. [Table 4A, column 0]
 - Average premiums in the standardized private non-group market are \$11,644 for single coverage and \$26,183 for family coverage.

Public/Private Hybrid Approaches.

To streamline the presentation of results, in the following discussion we present detailed results for 6 public/private hybrid models that delineate the basic building blocks of the approach. Full results for all models can be found in Appendix 4.

Simulation of Model 1-2: Public program expansions for all adults in families with incomes up to 200 percent of the FPL; summary Tables 1A-4A:

- Medicaid/CHIP coverage increases by about 775,000 people. ESI falls by about 260,000 people. Non-group coverage remains stable, leaving a net coverage increase of about half a million people.
- Under this public program expansion, the share uninsured declines by 19.6 percent. Some individuals are eligible for public insurance post-reform, but have not enrolled. Those individuals could be enrolled at very low or no cost in a public program. Taking those individuals into account, 94.1 percent of New York's residents would either have coverage or be eligible for a public program (Medicaid/CHIP) post-reform.
- Total government spending increases by \$2.3 billion. Employer spending decreases by \$0.9 billion; individual spending decreases by \$0.5 billion. However, savings of \$1.0 billion accrue to the low-income population, while the higher income groups' spending increases modestly.
- Government cost per newly insured is \$4,392.
- The share of employees offered ESI decreases by 4.3 percentage points among small firms and by 0.7 percentage points among large firms.

higher than typical single ESI premiums because the Medicaid/CHIP program covers many disabled people and a disproportionate number of individuals with high medical costs.

- There is virtually no change in employer premiums as a consequence of the public program expansion. There are some small declines in private non-group premiums as some workers who lose ESI coverage but do not qualify for public coverage purchase non-group coverage.
- Aggregate health system spending increases by \$931 million.

Simulation of Model 1-3: Public program expansions for all adults in families with incomes up to 200 percent of the FPL (Model 1-2) plus merge of the non-group market and small group market for firms up to 50 employees; summary Tables 1A-4A:

- Medicaid/CHIP coverage increases by slightly more than under the public expansion alone (850,000 people). ESI falls by somewhat more than the previous simulation, 440,000. Non-group increases by 200,000 as individuals gain access to a larger more diverse pool in which to purchase coverage. This produces a net coverage increase of 600,000.
- Under this voluntary system of reforms, the share uninsured declines by 22.4 percent. 94.2 percent of the state population is either eligible for public coverage (Medicaid/CHIP) or insured post-reform.
- Government spending increases by virtually the same amount as under the public expansion alone (\$2.5 billion); employer spending decreases by \$1.5 billion, as additional firms stop offering insurance coverage; individual spending decreases by \$0.3 billion, with the savings again accruing to the low-income population.
- Government cost per newly insured is \$4,089. The voluntary increase in unsubsidized coverage in the private non-group insurance market brings down the government cost per newly insured relative to the public expansion alone.
- The share of employees offered ESI decreases by 6.7 percentage points among small firms and 1.3 percentage points among large firms.
- While a merge of the small group and non-group markets alone would increase small group premiums but create much larger declines in non-group premiums, the changes are not as straight-forward when combined with a public program expansion as is the case here. In this situation, the Medicaid program expansion attracts some of the high cost low income population out of private insurance coverage at the same time as the small group and non-group pools are joined, bringing down the average cost of single policyholders in the private market. As the premiums in the private merged market decline as a result of the exit to Medicaid and the broader pooling, more healthy previously uninsured single people enter private coverage. As a consequence, small group single premiums actually decline somewhat as a result of the reforms. There is little change on net to family premiums since the entrance into private coverage and the exit from private coverage into Medicaid is dominated by singles, not families (because of the large number of singles below 200 percent FPL who become newly eligible). Very large premium savings are achieved in the non-group market – 56 percent on single policies and 43 percent on family policies.

NOTE: Average small group premiums are not exactly equal to non-group premiums after the markets are merged because a small share of small group employers are self-insured, and their premiums are reflected in the small group averages in the tables.

- Aggregate health system spending increases by \$644 million.

Purchasing pool coverage for individual non-group purchasers and small employers is included as a component of each of the following public/private hybrid models. Post-reform results for those obtaining coverage through the new purchasing pool are included in the ESI or non-group coverage totals depending on how they enroll in the pool.

Simulation of Model 1-8: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus purchasing pool, and Subsidy Schedule A for those up to 400 percent of the FPL; summary Tables 1B-4B:

- 825,000 people gain coverage under this reform. Medicaid/CHIP coverage increases by 924,000 people; however, ESI falls by 600,000 and non-group increases by 500,000.
- Under this voluntary system of reforms, the share uninsured declines by 30.4 percent. 95.3 percent of the population would either have coverage or be eligible for public program coverage (Medicaid/CHIP) post-reform.
- Total government spending increases by \$4.6 billion. Employer spending decreases by \$2.3 billion; individual spending decreases by \$616 million. Again, sizable savings accrue to the low income, with modest spending increases for the higher income.
- Government cost per newly insured is \$5,612.
- The share of employees offered ESI decreases by 5.8 percentage points among small firms. Some additional lower cost uninsured families join the subsidized private insurance pool, thereby lowering the family premiums for small employers and non-group purchasers somewhat further. There is a 1.6 percentage point decline in the share of employees offered ESI in large firms.
- Premiums for small employers fall post reform and those for large employers increase modestly. Large declines in non-group coverage premiums occur for both singles and families.
- Aggregate health system spending increases by \$1.7 billion.

The next model builds on Model 1-8 by adding an employer assessment (i.e., pay-or-play mandate) on employers. In this model (Model 1-13), there is an exemption for small firms with fewer than 10 workers from the employer assessment. See summary tables 1C-4C.

Simulation of Model 1-13: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL (Model 1-8), plus an employer pay-or-play mandate on employers of 10 or more employees. The employer assessment varies with each employee's wages and can be offset by employer spending on premiums.

- Medicaid/CHIP coverage increases by 909,000 people. ESI falls by 622,000 people. Non-group coverage increases by 589,000 people.
- Under this voluntary system of reform, the share of the population uninsured declines by 32.3 percent. 95.5 percent of the state's non-elderly population would either have insurance coverage or be eligible for public insurance (Medicaid/CHIP) under this approach.
- Subtracting out assessments paid by employers, leaves net new government spending increasing by \$4.5 billion. The more firms that are exempt from the assessment, the higher the net new government spending will be. Employer spending decreases by \$1.7 billion, with premium spending falling, but new assessments total \$900 million. Individual spending decreases by \$995 million.
- Gross government cost per newly insured is \$6,121; the net government cost (subtracting out the employer assessments) per newly insured is \$5,094.
- The share of employees offered ESI decreases by 4.4 percentage points among small firms, compared to a decrease of 5.8 percentage points without the employer pay-or-play mandate (Model 1-8). Smaller employers are least likely to offer under the current system and are therefore most likely to be affected by the new pay-or-play mandate. The offer rates for large firm workers falls by 0.6 percentage points post-reform.
- Private insurance premiums in the employer and non-group markets are just about the same as in Model 1-8.
- The aggregate change in health system spending would be \$1.8 billion dollars.

The next model, Model 1-17, builds on Model 1-13 by adding an individual mandate.

See summary Tables 1D-4D.

Simulation of Model 1-17: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL, and an employer assessment (i.e., pay-or-play mandate) with a small firm exemption for those with fewer than 10 workers (Model 1-13), plus an individual mandate. See summary Tables 1D-4D:

- Medicaid/CHIP coverage increases by 1.9 million people, ESI falls by about 170,000, and non-group increases by almost 1 million. Theoretically, this reform would reduce the number of uninsured to zero.
- Gross total government spending increases by \$8.0 billion (Table 2D, line b minus line a). Subtracting out assessments paid by employers, leaves net total government spending increasing by \$7.2 billion. Employer spending decreases by \$1.2 billion (premium spending falls, but new assessments add \$0.8 billion).

Individual spending stays essentially the same overall, but with \$1.6 billion in savings accruing to the low income households and increases in spending of \$1.5 billion in aggregate by the higher income.

- Gross government cost per newly insured is \$2,959; the net government cost per newly insured is \$2,663. The cost per newly insured is much lower under an individual mandate, as more healthy individuals and those that are not eligible for subsidies or public insurance are required to obtain coverage.
- The share of employees offered ESI decreases by 1.5 percentage points among small firms and by 0.1 percentage points for employees of large firms.
- Private insurance premiums in both the group and non-group markets are lower once a mandate is put in place, as the mandate brings in previously uninsured individuals who tend to be less costly on average than the insured.
- The aggregate change in health system spending under this reform is an additional \$6.0 billion dollars.

The final public/private hybrid model, Model 1-18, builds on Model 1-17 by adding a public insurance plan open to small employer and individual purchasers in the purchasing pool. See summary Tables 1D-4D.

Simulation of Model 1-18: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL, an employer assessment (i.e., pay-or-play mandate) on all employers (small firm exemption for those with fewer than 10 workers), and an individual mandate (Model 1-17) with a public insurance plan offered in the purchasing pool for small employer and individual purchasers. See summary Tables 1D-4D:

- The coverage effects under Model 1-18 are the same as those under Model 1-17, including coverage for all New York residents.
- Due to the savings realized by the presence of the public plan in the subsidized purchasing pool, government spending is slightly lower overall than under Model 1-17, with \$7.9 billion in total new government costs, which is reduced to \$7.1 billion once the employer assessments are netted out. Only 1/3 of the savings associated with the public plan option are assumed to be realized here, as this simulation represents an early year in the post-reform period. Employer and individual spending fall slightly as well compared to the previous model without the public plan option.
- Likewise, the government cost per newly insured is just slightly below that in Model 1-17, \$2,926* before assessments are netted out, and \$2,630* after.
- Offer rates are the same as in Model 1-17. The share of employees offered ESI decreases by 1.5 percentage points among small firms and by 0.1 percentage points for employees of large firms.
- Private insurance premiums within the purchasing pool fall modestly due to the presence of the public plan option. This is reflected in the small group and non-group premiums being slightly lower than in Model 1-17.

- The aggregate change in health system spending under this reform is an additional \$5.6 billion dollars.
- Larger long-run savings from the pool would increase the differences between Models 1-17 and 1-18 over subsequent years.

Public Health Insurance for All.

Simulation of Model 2-1: Public Health Insurance for All: Aside from Medicaid eligibles, all New York State residents would be enrolled in a fully publicly financed first-dollar coverage insurance plan. See summary Tables 1D-4D:

- Under this option, all those eligible for Medicaid would be automatically enrolled in that program, increasing the size of that program by 2.4 million people. All other state residents would be automatically enrolled in the new public plan and private coverage would be eliminated. There would be no remaining uninsured state residents.
- Redistribution of health system financing would be greatest under this model. The state's entire health care system would be funded through government spending. Total government health care spending would increase by \$57.7 billion. Employer spending on health care would be eliminated, saving employers \$33.3 billion in aggregate. Individuals would save \$22.0 billion in total, with \$11.8 billion in savings accruing to those who spend the most on health care today, those over 400 percent of the FPL.
- Employers would no longer offer health insurance to their workers.
- There would be no private insurance market remaining in the state, so there would not be private insurance premiums.
- The aggregate change in health system spending under this reform is an additional \$2.4 billion dollars. This is a significantly smaller addition to system spending than is the case under the other approaches that achieve coverage for all with an individual mandate that rely significantly on a subsidized private insurance market. Savings as a consequence of the lower payment rates to providers and lower administrative costs that would be achieved through a fully government sponsored program are what permit a substantial increase in coverage with a smaller net increase in overall spending.
- We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services in the amount of \$402 million. This unmet demand would lower the health care spending from the estimates provided above. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

New York Health Plus Plan.

Simulation of Model 3-1: The New York Health Plus plan: Family Health Plus coverage is made available to all state residents. A competing publicly run fee-for-service option, like traditional Medicare, is also available. Private and supplemental

health insurance coverage remains. Employer assessment of 10 percent of payroll, which can be offset by employer contributions to workers' health insurance. Physicians permitted to collectively negotiate payment rates with health plans and the state. See summary Tables 1D-4D:

- Due to aggressive auto-enrollment efforts, this plan is expected to eliminate uninsurance in the state. The current non-group insurance market would be eliminated. Employer sponsored insurance would decline by 6.2 million people (almost a 60 percent reduction), as individuals move into Family Health Plus. Family Health Plus would enroll 7.4 million people, and an additional 1.7 million would enroll in Medicaid.
- Total gross government costs would increase by \$47.5 billion. The employer assessment raises \$13.6 billion to offset the new costs of the reform, leaving net government costs post-reform of \$33.9 billion. Even with the large assessment, employers save \$9.9 billion in aggregate due to the substantial decline in employer-based insurance. Individuals save \$17.9 billion in aggregate, owing to the large scale shift from private to public coverage.
- The employer insurance offer rates for workers in small firms decreases by 32.0 percentage points and by 27.1 percentage points in large firms.
- Employer based insurance premiums fall significantly for both small and large employers as higher than average cost individuals move from employer coverage to the new public plan. A private non-group insurance market would not remain post-reform.
- The aggregate change in health system spending under this approach would be \$6.1 billion. This program maintains some private sector coverage post-reform and cannot achieve the same level of payment rate savings as Model 2-1 due to the ability of providers to collectively negotiate.
- We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services in the amount of \$1.0 billion. This unmet demand would lower the health care spending from the estimates provided above. This amount is higher than that under Model 2-1 because provider payment rates are higher under this approach. However, the speed with which supply expands in the long run under New York Health Plus may also be faster as a result. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

Modified “Freedom Plan” Approach.

Simulation of Model 4-1: Modified “Freedom Plan” approach. Introduction of high deductible policy into the private non-group market; increased rating flexibility in non-group products based upon health care risk; additional \$31 million contributed to state's government-funded reinsurance for non-group market; subsidies for the purchase of small group and non-group policies (modeled as subsidies phased-in in year 3 post implementation, 15 percent of employer share in small group market and 15 percent of full non-group premium). See summary Tables 1D-4D:

- The net change in insurance coverage is very small in this model. Medicaid/CHIP coverage barely increases on net. While some uninsured enroll in Medicaid as a consequence of the expansion for children to 400 percent of the FPL (a reform already implemented in the state and included in each reform simulation in this report), others with Medicaid move out of the program and into employer-based coverage once the reforms are in place and employer sponsored premiums fall in the private market. Non-group coverage increases by 400,000 and employer-based coverage falls on net by a very small amount. While some gain employer coverage, others migrate to non-group coverage to take advantage of the new flexibility in premium rating rules. Also, a small share of large firm workers lose their offer of health insurance, and not all of those workers obtain coverage through non-group or Medicaid, becoming uninsured.
- One significant consequence of introducing a high deductible option into the non-group market is that positive risk selection into that new option undermines the comprehensive coverage product to such an extent that it is no longer viable in the marketplace. As a consequence, the high cost population enrolled pre-reform in more comprehensive non-group coverage would be faced with higher out-of-pocket costs when shifted to the new more parsimonious plans.
- Under this reform, the number of uninsured in the state declines by 15.4 percent. Post-reform, 92.6 percent of state residents either have coverage or are eligible public insurance (Medicaid/CHIP).
- Total government costs increase by \$2.7 billion. Employer spending falls by \$2.1 billion due to the subsidies for small employers. Individual spending increases post-reform by \$1.2 billion, with those costs accruing largely to those over 200 percent of the FPL.
- While the coverage effect is quite small, the government cost per newly insured person is quite high -- \$6,605. The subsidy dollars directed to small employers and purchasers of non-group insurance largely go to those who were insured prior to reform since the new government assistance is insufficient to attract many previously uninsured individuals or firms into the insurance market. The aggregate change in health system spending under this approach would be \$1.9 billion.

Section 5. 5 and 10 Year Results for Models 1-3, 1-17, 2-1 and 3-1

In Section 4, reform options were simulated in the year 2009, with the 2009 population and 2009 dollars, as if the reforms had been implemented and in place for 3 years. In this section we report how reform costs and coverage are expected to evolve over time for four key reforms: public/private hybrid Models 1-3 and 1-17, Public Health Insurance for All (Model 2-1), and New York Health Plus plan (Model 3-1). In particular, we present cost and coverage estimates for the four approaches as they would appear in implementation years 5 (i.e., 2014), and 10 (i.e., 2019). The 2014 and 2019 numbers reflect full implementation of the policies and behavioral responses to the policies.

Aging the reform results out to future years takes several additional factors into account. These additional factors include health care cost and premium growth, changes in wages and incomes, and demographic shifts. For both the 2009 to 2014 and the 2014 to 2019 periods, we assume:

- Health care cost growth of 6 percent per year.
- ESI and non-group premium growth of 7.5 percent per year.
- Shifts in New York's population, by age and gender, as projected by the U.S. Census Bureau.

The aging from 2009 to 2014 also takes into account some expected effects of the economic downturn. We make the following additional assumptions regarding the 2009 to 2014 period:

- Annual growth in the Consumer Price Index (CPI) of 2 percent. We adjust poverty thresholds each year as they are indexed to the CPI.

- Wage growth of 2 percent per year on average, with families (i.e., health insurance units) in the lowest quintile of family wage earnings experiencing wage growth of 1 percent and families in the highest wage quintile experiencing growth of 4 percent. We apply the same growth rate to total family income as we do to family wages.
- A shift in employment from large employers to smaller employers at an annual rate similar to that observed in the economic downturn from 2000 to 2004.
- A shift in employment from firms that offer ESI to firms that do not-offer ESI, with families in the lowest wage quintile experiencing an 8 percent loss in offer rates, to families in the highest quintile experiencing a 1 percent loss in offer rates.³¹
- An unemployment rate of 5.1 percent in 2014, as recently projected by the Congressional Budget Office, reflecting a return to full employment by 2014. We project an associated employment to population ratio of 62.8 percent.

In the 2009 to 2014 period, the CPI, wage, and income growth assumptions are set below their typical levels to reflect low aggregate demand and weakness in the labor market. In addition, high-wage workers have seen their wages grow faster annually than low-wage workers over many years, and we assume that trend continues. Although the CBO has projected a return to full employment by 2014, and analyses suggest that ESI coverage recovers as unemployment rates fall, part of the recovery in coverage occurs with a lag.³² Employers that drop coverage during the recession may not start offering again immediately following a return to full employment.

For the 2014 to 2019 period, we assume typical levels of price and wage growth and continued full employment:

- Annual growth in the Consumer Price Index (CPI) of 2.5 percent.

³¹ Clemans-Cope, Lisa, and Bowen Garrett. (December 2006). "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005." Issue paper. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

³² John Holahan and Bowen Garrett (January 2009). "Rising Unemployment, Medicaid and the Uninsured." Policy brief. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

- Wage growth of 3 percent per year on average, with families in the lowest wage quintile experiencing wage growth of 2 percent and families in the highest wage quintile experiencing growth of 5 percent.
- No separate shifts in the distribution of employees by firm size or ESI offer status.
- The same unemployment rate (5.1 percent) and employment to population ratio (62.8 percent) in 2019 as we assumed for 2014.

According to the Census Bureau, New York State population growth is rather flat overall and is only expected to grow by 0.7 percent from 2010 to 2020.³³ The population age 65 and over in New York, however, is projected to grow by 22.6 percent over that same time period. There is also substantial growth in the age 55 to 64 population. The population in several younger age groups (e.g., 18- to 24-year-olds) is falling, as is the under age 65 population in New York as a whole.

In modeling the cost and coverage options 5 and 10 years post-implementation, we simulate the effects of the policies themselves, as well as the effects of health care and health insurance becoming more expensive as compared to family incomes. As the price of health insurance rises faster than incomes, private insurance becomes less affordable and some may opt for public coverage if they are eligible or become uninsured. There is also an effect of health insurance coverage becoming more costly as compared to underlying health care costs. Demand for private coverage falls when premiums grow faster than the cost of health care itself.

We report results for post-implementation coverage for Model 1-3 in Table 5. To review, Model 1-3 contains public program expansions for all adults in families with incomes up to 200 percent of the FPL, and a merge of the non-group market and small

³³ State Interim Population Projections by Age and Sex: 2004 – 2030. U.S. Census Bureau. <http://www.census.gov/population/www/projections/projectionsagesex.html>.

group market for firms up to 50 employees. For Model 1-3, there would be a somewhat smaller number of people with ESI and non-group coverage in 2014 as compared to the reform results for 2009, and a smaller number still in 2019. Part of the decline in both periods results from the rise in health care costs relative to wages. The additional rate of decline seen from 2009 to 2014 largely reflects the more pessimistic economic assumptions we applied over that period. The number with Medicaid/CHIP coverage would be higher at 4.8 million in 2014 and about 4.9 million in 2019, compared to 4.5 million in 2009. The rise in public coverage more than offsets the fall in private coverage, leaving the number of uninsured with a small decline in each year. The Medicaid/CHIP expansion provides some protection to coverage when health care costs rise faster than incomes and offer rates fall. Demographic shifts from young age groups who are more likely to be uninsured to older age groups who are less likely to be uninsured may also contribute to the decline in the projected number of uninsured over time in this reform model.

The reform results for post-implementation costs are reported in Table 6. For Model 1-3, Medicaid/CHIP costs would be \$41.0 billion in 2014 and \$52.3 billion in 2019 compared to \$31 billion in 2009 under reform. Employer costs would rise to \$41.3 billion in 2014 and \$55.4 billion in 2019 from \$31.8 billion in 2009. Individual costs would be \$26.9 billion in 2014 and \$34.8 billion in 2019 as compared to \$21.7 billion in 2009.

Post-implementation coverage results for Model 1-17 are also reported in Table 5. To review, Model 1-17 contains the reforms in Model 1-3, plus a purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL, an employer assessment (i.e.,

pay-or-play mandate) with a small firm exemption for those with fewer than 10 workers, and an individual mandate. ESI coverage in reform falls in 2014 as compared to 2009 and falls further in 2019. This is largely driven by the increased cost of ESI relative to incomes but also reflects the fall in offer rates in the 2009 to 2014 period. Non-group coverage falls from 2009 to 2014, primarily driven by increased premium costs and lower income growth, but increases very slightly in 2019. Demographic trends and higher income growth in this period is likely to offset what would otherwise be a decline in non-group coverage due to rising premium costs. Medicaid/CHIP coverage rises from 2009 to 2014 but then falls slightly. This pattern is consistent with the fall in offer rates specific to the 2009 to 2014.

Medicaid/CHIP costs would increase to nearly \$48.8 billion in 2014 and \$64.5 billion in 2019 for Model 1-17 as compared to \$36.6 billion in 2009 (see Table 6). Employer spending increases to \$38.6 billion in 2014 and \$47.0 billion in 2019 from \$31.3 billion in 2009. Employer assessments increase to \$956 million in 2014 and \$1,072 million in 2019, compared to \$803 million in 2009. The assessments, based on wages, grow more slowly than employer spending on premiums. Individual spending increases to \$37.1 billion in 2014 and \$55.5 billion in 2019 as compared to \$25.1 billion in 2009. The high rate of growth in individual spending primarily reflects premiums growing at 7.5 percent per year. It also reflects the upward shift in the age distribution towards people with higher out-of-pocket costs. Subsidies increase to \$5.4 billion in 2014 and nearly \$10 billion in 2009 as premiums rise and more people become eligible for subsidies and those who are already eligible become eligible for larger ones. The

faster rise in subsidies helps reduce the rate of growth in post-subsidy individual spending.

Post-implementation coverage results for Model 2-1 (Public Health Insurance for All) are reported in Table 7. In Model 2-1, all New York State residents would be enrolled in a fully publicly financed first-dollar coverage insurance plan. Because nearly all non-Medicare New York State residents would be covered by the Public Health Insurance for All program or Medicaid/CHIP, the number that have public coverage is relatively flat and reflects only demographic trends. Post-implementation cost results for Model 2-1 are reported in Table 8. Total government spending rises from \$86 billion to \$108 billion in 2014 and \$130 billion in 2019. The changes in spending over time reflects the assumed rates of health care cost growth, reduced by the cost containment factors that are assumed to be achievable under this reform, as described in Section 3.

Post-implementation coverage results for Model 3-1 (New York Health Plus plan) are reported in Table 7. Under this reform, Family Health Plus coverage is made available to all state residents. A competing publicly run fee-for-service option, like traditional Medicare, is also available. Private and supplemental health insurance coverage remains. There is an employer assessment of 10 percent of payroll, which can be offset by employer contributions to workers' health insurance. Physicians are permitted to collectively negotiate payment rates with health plans and the state. Nearly 12.8 million residents would be enrolled in either Medicaid/CHIP or the new FHP program. This number would rise to 13.1 million in 2014 and 13.3 million in 2019 as rising health care costs increase the benefit of opting for FHP. Almost 4.4 million residents would continue to hold coverage through their employers, which would fall to

3.5 million in 2019. Cost results over time for Model 3-1 are reported in Table 8.

Government spending, net of employer assessments, would grow from \$62 billion to \$84 billion in 2014 and \$106 billion in 2019. This growth reflects the assumed growth rates for health care costs and the cost containment assumptions specific to this plan which are described in Section 3. Employer costs, including the employer assessments, would grow from \$23 billion to \$29 billion in 2014 and \$37 billion in 2019 as some employers continue to provide coverage under this reform. Individual costs would rise from \$4.1 billion to \$5.0 billion in 2014 and \$6.0 billion in 2019 for those individuals who continue to hold ESI policies under this reform.

Section 6. Responses to Criteria Specified in the Request for Proposal (RFP)

The analyses of proposals included in this report respond to the Request for Proposals (RFP) issued by the State of New York on July 9, 2007.³⁴ The 2007 RFP included criteria to be addressed in the analysis. Below we list each criterion and describe how each was addressed in the report.

“The contractor must model proposals for universal health coverage that reflect publicly sponsored coverage that rely on broad based public-financing. Such proposals will include a public payer model of health insurance coverage as well as models which rely on publicly financed coverage delivered through private sector insurers and/or a combination of public payer and private insurers.”

The reform options modeled in this report include both the public payer model of health insurance coverage—see the Public Health Insurance for All and the New York Health Plus plan approaches—and the combination of public payer and private insurers—see the “Public/Private hybrid” approaches. In addition, we modeled the modified “Freedom Plan” approach.

The RFP also specified that the analysis of these proposals include the following estimates—described in criteria 1 through 5—which we respond to in turn, below.

1. *“Cost of the proposal and how that cost is distributed among government, employers and consumers”*

Each reform approach is associated with different cost estimates for government, employers, and individuals. For each group, cost estimates show costs in baseline and under reform. Since the share of new spending paid by the federal government is uncertain, we present government costs as total federal and state spending. Employers’ assessment costs, if applicable, under reform are shown separately from employer

³⁴ See <http://www.nyhealth.gov/funding/rfp/0706041203/0706041203.pdf>.

premium costs under reform. Changes in costs for individuals are shown by household income level.

2. *“Extent to which the proposal advances the goal of universal coverage and reduces barriers to coverage”*

Estimates of coverage under reform are provided for all proposals. Proposals including an individual mandate or public coverage for all ensure that the whole population is insured, even those who might otherwise prefer to remain uninsured. The extent to which proposals calling for voluntary coverage reduce barriers to coverage is shown through the number of uninsured individuals voluntarily taking up coverage.

3. *“Impact of the proposal on the business community including small business, self employed individuals and sole proprietors. This should include an assessment of the impact of the proposal on employment as well as on collective bargaining agreements.”*

For each proposal, we simulate the impact of reform on employers of several employment size categories and industries, reflecting New York State’s mix of employer types. In the tables contained in this report, we show changes in the rate of offer of health insurance separately for small firms (those with up to 50 employees) and large firms (those with 50 or more employees). Self employed persons and sole proprietors are included in the data reflecting the employment patterns of New Yorkers, and thus are included in all coverage and cost estimates. In forthcoming analysis, the Regional Economic Models Incorporated (REMI) Policy Insight framework will be used to assess the economic impacts of the health reform options on employment, overall economic activity, and other macroeconomic factors. This model is based on econometric relationships that reflect how the various sectors of the economy interact, including how labor can flow between sectors depending on changes in demand. We were unable to evaluate the effect of the reforms on collective bargaining agreements.

4. *“Impact of the proposal on the provider community.”*

For each reform proposal analyzed, we provide an estimate of the change in system-wide health care spending that would result. This aggregate change in spending reflects increased resources devoted to health care providers. The analysis contained in this report also recognizes that the ability of health care reform to increase access to health care for New Yorkers depends not only on coverage expansions but on health care providers and the supply of services. For each reform, we estimate whether and to what extent the health care delivery system would encounter significant additional capacity constraints. For this analysis, we estimate the effects on existing primary care physician and hospital capacity. (See Appendix 3.)

5. *“Impact of the proposal on general scope of benefits, quality of care provided and consumer choice of provider.”*

Scope of benefits is addressed by comparing pre-reform premium and out-of-pocket spending by individuals and families to post-reform spending on premiums and out-of-pocket costs. There are differences in benefits that are imbedded in certain reform options (e.g., high deductible non-group coverage, first dollar public coverage, the Family Health Plus benefit package) and individuals would change the scope of coverage obtained depending upon the options and incentives provided. Such changes in scope of benefits are reflected in the changes in individual spending provided in the report by income group. Quality of care and consumer choice considerations are reflected in the coverage decisions that individuals are simulated to make and the extent to which supply constraints impact the health care delivery system. To the extent that a reform leaves the underlying structure of coverage intact, impacts on quality of care and consumer choice would be limited.

Section 7. Discussion

A variety of approaches are available to significantly increase insurance coverage among New York State residents. Each approach has different distributional implications for government, employers, and individuals. Providing meaningful coverage to the uninsured would bring significant health, economic, and social benefits; however, broad based system reform will necessitate the state making difficult tradeoffs as the objectives of different stakeholders are balanced.

This report details the coverage and cost implications for 21 health care reform options falling into four categories: public-private insurance hybrids, Public Health Insurance for All, the New York Health Plus plan, and the modified “Freedom Plan” approach. Each component of a reform’s design carries trade-offs with regard to private versus public costs. For example, the greater the subsidization of coverage, the greater the level of government funding required, but the greater will be the savings to households and employers. An individual mandate ensures that the whole population will be insured, but imposes costs on some who would prefer to remain uninsured. The results for each of the 21 reform options are fully described in Appendix 4. The following are our key findings.

Public/Private Hybrid Approaches.

(1) Public expansions for at least the lowest income adults can cover significant numbers of uninsured New Yorkers at a relatively low cost.

Expansions of current public programs are a fundamental component of all but one of the reform approaches simulated here. These expansions (coupled with the recently implemented expansion for children up to 400 percent of the FPL) are well-

targeted strategies that alone lead to significant expansions of insurance coverage (covering 13 to 20 percent of the uninsured), while providing comprehensive no-cost coverage to those least able to affordably access care through the private insurance system. New government costs for the expansions analyzed ranged from \$1.5 to \$2.3 billion, and resulted in employer and individual savings. Limiting public program expansions to those adults below 200 percent of the federal poverty level means that the vast majority of new Medicaid/CHIP enrollees were previously uninsured. In other words, displacement of private insurance coverage is low, and the impact on employer offers is very small. If the public expansions were to go substantially higher up the income scale, the share of those covered by the public programs who would otherwise have had private coverage would increase since those with higher incomes are much more likely to have private insurance pre-reform, and we would likely see a larger decline in offers of employer-based insurance.

(2) A merge of the non-group and small group insurance markets would significantly reduce premiums associated with non-group coverage while increasing small group premiums somewhat.

The dynamics of that change, however, are significantly affected by interactions with the public program expansion for adults, as discussed in Section 4. Adding a merge of the non-group with the 50-or-fewer-employee small group market increases coverage by over 74,000 people relative to the public expansion alone, as more individuals voluntarily buy coverage in the non-group market. The cost per newly insured falls relative to the public expansion alone, since the merge increases the take-up of private unsubsidized insurance. Individual spending increases as more people buy private insurance. There is a modest decline in employer-based insurance offers for small firm

employees as the non-group market becomes more attractive. These declines and the increase in non-group insurance lead to employer savings of approximately \$1.5 billion.

(3) There is very little difference between the merge involving firms of up to 50 versus up to 100 employees.

Relatively few employees, just 569,000 people, work in firms with 50 to 99 employees compared to the 2.8 million employees in firms with fewer than 50 employees. Thus, differences between the pooling of firms up to 50 versus up to 100 employees are quite small. Moreover, the cost of providing reinsurance to keep single and family premiums in the small group market from increasing under a market merge would be relatively low, given the interaction between the merge and the public expansion for adults.

(4) Introducing income related subsidies for the voluntary purchase of private insurance plans in a purchasing pool would cover another one-third of the uninsured population.

Depending upon the level of the subsidies, 28 to 36 percent of the uninsured would be covered under a voluntary approach that is combined with the public expansion and the merge of non-group with small group. This approach would result in 50 to 70 percent (depending upon the subsidy schedule) of formerly uninsured, subsidy eligible individuals voluntarily taking up coverage. This voluntary expansion of coverage with a public expansion, income related subsidies, and a purchasing pool would cost \$4.3 to \$8.1 billion in government spending, depending upon the level of the subsidy schedule.

(5) Voluntary approaches that would provide subsidies but not mandate coverage provide benefits to low and middle income families beyond initial coverage impacts.

Focusing only on the reduction in the number of uninsured understates the full benefits of voluntary approaches. In Model 1-2, for example, which includes the public

coverage expansion up to 200 percent of poverty for adults, there are 1.2 million people who are eligible for free coverage under Medicaid/CHIP, yet do not participate and remain uninsured. The proposal still benefits these individuals to the extent that they would enroll or be enrolled if they became ill and needed medical care, however, any potential savings and quality of care improvements associated with preventive care or early primary care intervention would not be realized by those unaware that they effectively have comprehensive insurance coverage. Similarly, later models that include subsidies in the new purchasing pool provide benefits to families with moderate incomes who may have already had coverage prior to reform by freeing up some funds which they had been using for health care for other purposes.

(6) Higher subsidies, including extending them to higher income levels, does not provide a large gain in insurance coverage.

This is because most higher-income individuals already have health insurance coverage, and because a segment of the population will not choose to voluntarily purchase coverage even when offered quite extensive subsidies since they do not expect to use significant amounts of health care services. The same would not necessarily be true in other states or nationally without pure community rating in the subsidized market, since greater subsidization would make coverage more affordable for older individuals who face higher premiums due to age rating.

(7) While coverage does not increase substantially with higher subsidies, government costs are quite sensitive to the subsidy level.

The highest subsidy schedule (B for those with incomes up to 600 percent of the FPL) would increase government costs by \$8.1 billion, compared to \$4.6 billion when using schedule A for those with incomes up to 400 percent of the FPL. Combined with

the fact that the increase in coverage that can be obtained from the higher subsidies is quite small, these additional subsidies do not provide much additional “bang for the extra government buck.” Employer offer rates do fall somewhat as well with increased subsidies available to non-group enrollees. As a consequence, savings of \$2.0 to \$3.0 billion accrue to employers under the voluntary reforms that include a purchasing pool and subsidies.

(8) An individual mandate, along with income related subsidies and other reforms, reduces the government cost per newly insured person; that is, the incremental cost of the mandate is relatively low.

Many of those enrolling in coverage only under a mandate are healthier and would receive only partial or no government subsidies, making them less expensive to the public sector when enrolled. Private spending increases, however, both for individuals and employers. Once everyone is required to have health insurance of some type, more people will decide that their best coverage option is through their employers. Employer sponsored insurance offers thus increase relative to the voluntary approach, as more employees choose to trade off wages for employer health insurance benefits. While an individual mandate clearly brings efficiencies in this respect, the tradeoff is that individuals lose some personal choice in how they allocate their resources between health insurance and other goods and services. With Schedule A subsidies up to 400 percent of the FPL, new government costs for achieving coverage for all residents would be approximately \$7.1 billion, an increase of 25.0 percent relative to current government spending for acute care for the non-elderly.

(9) The effect of employer assessments depends in part on firm size exemptions.

The larger the size of firms exempted from the employer assessments, the less is the impact of such pay-or-play employer mandates. Small employers are those that are the least likely to offer coverage to their employees today; the vast majority of large employers do offer. So if the employer mandate only applies to large firms, it will have little practical impact – those employers currently offer, and would continue to do so. As the exemption shrinks or is eliminated altogether, the revenue collected from the assessment increases and coverage and employer offer rates increase modestly. The more firms that pay the assessment, the less revenue the government has to raise from other sources to finance the reforms, but the higher is employer spending.

(10) Employer spending increases when an individual mandate is added on to an employer pay-or-play mandate.

Under an individual mandate, those who may have had employer offers but not taken them will be very likely to enroll in that coverage. As a consequence, employer spending will rise compared to the same type of reform without an individual mandate. Under all the pay-or-play mandate approaches, however, the biggest increases in employer costs are borne by those employers that did not previously provide health insurance to their employees.

(11) Introducing a public plan option into the purchasing pool is estimated to save both government subsidies and private spending through increased market competition and reduced administrative costs.

This occurs because of lower provider payment rates and administrative costs in the public plan; moreover competition from the public plan is assumed to lower private

plan costs. The savings should increase over time as the public plan gains market share and brings its buying power into negotiations over payment rates with providers.

Public Health Insurance for All.

(12) A plan that eliminates private insurance markets in the state and automatically enrolls all residents of the state into a comprehensive public insurance plan would result in a large redistribution of health care financing resources.

The state's entire health care system would be funded through government spending. Total government health care spending would increase by \$57.7 billion. Employer spending on health care would be eliminated, saving employers \$33.3 billion in aggregate. Individuals would save \$22.0 billion in total, with \$11.8 billion in savings accruing to those who spend the most on health care today, those over 400 percent of the FPL.

(13) Public Health Insurance for All would result in a significantly smaller addition to health system spending than Individual Mandate approaches that achieve coverage for all largely through a subsidized private insurance market.

The aggregate change in health system spending under this reform is an additional \$2.4 billion dollars. Savings as a consequence of the lower payment rates to providers and lower administrative costs that would be achieved through a fully government sponsored program are what permit a substantial increase in coverage with a smaller net increase in overall spending.

(14) Public Health Insurance for All would result in some provider capacity constraints.

We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services, at least in the near term, in the amount of \$402 million. The shortfall in supply of medical services relative to demand is the consequence of providing first dollar comprehensive health insurance coverage to all

residents. The unmet demand lowers the health care spending from the estimates provided in this report. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

New York Health Plus Plan.

(15) A plan with a large payroll tax assessment on non-offering employers that expands public program eligibility to all individuals, regardless of income, will result in somewhat less redistribution of health care financing than if the public insurance plan is the only system.

This plan is expected to eliminate uninsurance in the state, due to aggressive auto-enrollment efforts. The current non-group insurance market would be eliminated. Employer sponsored insurance would decline by 6.2 million people (almost a 60 percent reduction), as individuals move into Family Health Plus plans. Family Health Plus would enroll 7.4 million people, and an additional 1.7 million would enroll in Medicaid.

This plan would increase government costs by \$33.9 billion (net of the employer assessment revenue of \$13.6 billion) but would save employers and individuals \$9.9 billion and \$17.9 billion respectively, owing to the large scale shift from private to public coverage. Employer based insurance premiums fall significantly for both small and large employers as higher than average cost individuals move from employer coverage to the new public plan.

(16) The New York Health Plus plan would result in higher health system spending and higher provider capacity constraints compared to the Public Health Insurance for All approach.

The aggregate change in health system spending under this approach would be \$6.1 billion. This program cannot achieve the same level of payment rate savings as Public Health Insurance for All due to the ability of providers to collectively negotiate in the New York Health Plus plan.

We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services, at least in the near term, in the amount of \$1.0 billion. This is higher than the amount of unmet demand under the Public Health Insurance for All Plan because the price per unit of service is higher. However, the speed with which supply expands in the long run under New York Health Plus may also be faster as a result. This unmet demand would lower the health care spending from the estimates provided in this report.

Modified “Freedom Plan” Approach.

(17) The modified “Freedom Plan” approach has the least impact on insurance coverage and, as a consequence, has the smallest total government outlays of the reforms we modeled.

With modest premium subsidies for small employers and individual purchasers, the biggest impact of this plan comes from introducing flexibility in setting premiums—resulting in variation by age and health-status—and high-deductible coverage options in the non-group insurance market. While the number of uninsured decreases by only 15 percent (with most of that attributable to the already implemented public expansion for children), comprehensive coverage in the non-group market is all but eradicated by the introduction of high-deductible plans. While the coverage impact of this approach is very small, the government cost per newly insured is significantly higher than almost all of the other voluntary reforms.³⁵

³⁵ The two exceptions are Models 1-9 and 1-10 which used the most generous subsidy schedule of all of the voluntary reforms.

Summary Tables

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 1A
Health Insurance Coverage**

Model	0		1-1		1-2		1-3		1-4		1-5	
Description (see notes for more detail)	Baseline		Public Expansion: <i>Children to 400%</i> <i>Adults to 160%</i>		Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i>		Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Voluntary		Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 100 w/NG Voluntary		Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG w/Gov't Reinsurance Voluntary	
Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
<i>ESI</i>	10,506	61.1%	10,332	60.1%	10,244	59.6%	10,062	58.5%	10,091	58.7%	10,081	58.6%
<i>Non-Group</i>	248	1.4%	266	1.5%	268	1.6%	449	2.6%	436	2.5%	445	2.6%
<i>Medicaid/CHIP</i>	3,674	21.4%	4,193	24.4%	4,448	25.9%	4,523	26.3%	4,522	26.3%	4,527	26.3%
<i>Other*</i>	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%
<i>Uninsured</i>	2,711	15.8%	2,349	13.7%	2,179	12.7%	2,105	12.2%	2,091	12.2%	2,088	12.1%
<i>Difference**</i>												
<i>ESI</i>	-	-	-173	-1.0%	-261	-1.5%	-443	-2.6%	-415	-2.4%	-425	-2.5%
<i>Non-Group</i>	-	-	17	0.1%	19	0.1%	201	1.2%	187	1.1%	196	1.1%
<i>Medicaid/CHIP</i>	-	-	519	3.0%	774	4.5%	849	4.9%	848	4.9%	852	5.0%
<i>Uninsured</i>	-	-	-363	-2.1%	-532	-3.1%	-606	-3.5%	-621	-3.6%	-624	-3.6%
% decline in uninsured		-		-13.4%		-19.6%		-22.4%		-22.9%		-23.0%
% covered or eligible for public		90.8%		92.9%		94.1%		94.2%		94.3%		94.3%

Source: Urban Institute analysis, HIPSM 2009.

Note: Those with Medicare coverage are excluded from this table.

Model 1-5 includes an employer assessment on employers with 50 or more employees. The assessment is offset dollar for dollar by any employer premium contributions made on behalf of employees. The assessment varies with the wage level of the individual employee.

wage level of the individual employee.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

* There is no change in other public coverage between baseline and reform

** Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results
Summary Table 2A
Health Care Spending**

Model	1-1	1-2	1-3	1-4	1-5
Description (see notes for more detail)	Public Expansion: Children to 400% Adults to 160%	Public Expansion: Children to 400% Adults to 200%	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Voluntary	Public Expansion: Children to 400% Adults to 200% Merge < 100 w/NG Voluntary	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG w/Gov't Reinsurance Voluntary
(in millions, 2009 \$)					
Total Government Spending (federal + state)					
<i>a. Baseline</i>	\$28,545	\$28,545	\$28,545	\$28,545	\$28,545
<i>b. Gross Post-Reform</i>	\$30,039	\$30,882	\$31,025	\$31,042	\$31,159
<i>c. Empl. Assess. if app.</i>	\$0	\$0	\$0	\$0	\$0
<i>d. b-c</i>	\$30,039	\$30,882	\$31,025	\$31,042	\$31,159
<i>e. Net Chng Post Reform</i>	\$1,494	\$2,337	\$2,480	\$2,497	\$2,614
<i>f. % Chng Post Reform</i>	5.2%	8.2%	8.7%	8.7%	9.2%
<i>g. Net Govt Cost/Newly Insured</i>	\$4,117	\$4,392	\$4,089	\$4,023	\$4,192
<i>h. Net Govt Cost/Newly Insured, Post Assessment</i>	n/a	n/a	n/a	n/a	n/a
Employer Spending					
<i>i. Baseline</i>	\$33,321	\$33,321	\$33,321	\$33,321	\$33,321
<i>j. Post-Reform</i>	\$32,752	\$32,452	\$31,806	\$31,802	\$31,884
<i>k. Empl. Assess. if app.</i>	\$0	\$0	\$0	\$0	\$0
<i>l. j+k</i>	\$32,752	\$32,452	\$31,806	\$31,802	\$31,884
<i>m. Net Chng Post Reform</i>	-\$569	-\$869	-\$1,515	-\$1,520	-\$1,437
<i>n. % Chng Post Reform</i>	-1.7%	-2.6%	-4.5%	-4.6%	-4.3%
Individual Spending					
<i>o. Baseline</i>	\$22,033	\$22,033	\$22,033	\$22,033	\$22,033
<i>p. Post-Reform</i>	\$21,793	\$21,496	\$21,712	\$21,660	\$21,690
<i>q. Government Subs. if app.</i>	\$0	\$0	\$0	\$0	\$0
<i>r. p-q</i>	\$21,793	\$21,496	\$21,712	\$21,660	\$21,690
<i>s. Net Chng Post Reform</i>	-\$240	-\$537	-\$321	-\$373	-\$343
<i>t. <200% of the federal poverty level</i>	-\$576	-\$1,028	-\$1,115	-\$1,118	-\$1,123
<i>u. 200-399% of the federal poverty level</i>	\$186	\$253	\$471	\$434	\$433
<i>v. 400%+ of the federal poverty level</i>	\$150	\$237	\$323	\$311	\$347
<i>w. % Chng Post Reform</i>	-1.1%	-2.4%	-1.5%	-1.7%	-1.6%
Aggregate Change (e+m+s)	\$685	\$931	\$644	\$604	\$834

Source: Urban Institute analysis, HIPSM 2009.

Notes: Base government spending includes acute care for the non-elderly population. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. n/a stand for not applicable. Uncompensated care costs and how they change under the different policy options are not reported.

Model 1-5 includes an employer assessment on employers with 50 or more employees. The assessment is offset dollar for dollar by any employer premium contributions made on behalf of employees. The assessment varies with the wage level of the individual employee.

Line g is calculated by subtracting line b from line a, then dividing by the number of newly insured. Line h is calculated by subtracting line a from line d, then dividing by the number of newly insured.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 3A
Share of Employees with Employer Sponsored Insurance Offers, by Firm Size**

Model	0	1-1	1-2	1-3	1-4	1-5
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 160%</i>	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i>	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 100 w/NG Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG w/Gov't Reinsurance Voluntary
Post-Reform Offer						
<i>Small Firms</i>	63.1%	59.8%	58.8%	56.4%	56.5%	56.5%
<i>Large Firms</i>	92.0%	91.3%	91.2%	90.7%	90.8%	90.3%
<i>Overall</i>	82.7%	81.2%	80.9%	79.7%	79.8%	79.5%
Difference*						
<i>Small Firms</i>	-	-3.3%	-4.3%	-6.7%	-6.6%	-6.6%
<i>Large Firms</i>	-	-0.7%	-0.7%	-1.3%	-1.2%	-1.7%
<i>Overall</i>	-	-1.5%	-1.9%	-3.0%	-2.9%	-3.2%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Model 1-5 includes an employer assessment on employers with 50 or more employees. The assessment is offset dollar for dollar by any employer premium contributions made on behalf of employees. The assessment varies with the wage level of the individual employee.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

* Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 4A
Health Insurance Premiums, by Firm Size**

Model	0	1-1	1-2	1-3	1-4	1-5
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 160%</i>	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i>	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 100 w/NG Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG w/Gov't Reinsurance Voluntary
Average Post-Reform Employer-Sponsored Insurance Premiums (in 2009\$)						
<i>Small Firms</i>						
<i>Single</i>	\$5,994	\$5,936	\$5,948	\$5,405	\$5,479	\$5,396
<i>Family</i>	\$15,253	\$15,130	\$15,168	\$15,398	\$15,236	\$15,153
<i>Large Firms</i>						
<i>Single</i>	\$5,240	\$5,260	\$5,260	\$5,327	\$5,266	\$5,334
<i>Family</i>	\$13,408	\$13,458	\$13,459	\$13,631	\$13,574	\$13,648
Difference						
<i>Small Firms</i>						
<i>Single</i>	-	-\$57	-\$46	-\$589	-\$515	-\$597
<i>Family</i>	-	-\$123	-\$85	\$145	-\$17	-\$100
<i>Large Firms</i>						
<i>Single</i>	-	\$20	\$20	\$87	\$26	\$94
<i>Family</i>	-	\$50	\$51	\$223	\$166	\$241
Post-Reform Private Non-Group Insurance Premiums (in 2009\$)						
<i>Single</i>	\$11,644	\$11,400	\$11,320	\$5,130	\$5,222	\$5,117
<i>Family</i>	\$26,183	\$25,789	\$25,582	\$14,982	\$14,822	\$14,700
Difference						
<i>Single</i>	-	-\$244	-\$323	-\$6,513	-\$6,421	-\$6,527
<i>Family</i>	-	-\$394	-\$601	-\$11,202	-\$11,362	-\$11,483

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Standardized private non-group premiums in the baseline are compared to premiums in the post-reform non-group market.

Model 1-5 includes an employer assessment on employers with 50 or more employees. The assessment is offset dollar for dollar by any employer premium contributions made on behalf of employees.

The assessment varies with the wage level of the individual empl

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results
Summary Table 1B
Health Insurance Coverage**

Model	0		1-6		1-7		1-8		1-9		1-10	
Description (see notes for more detail)	Baseline		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Employer assessment varies, under 50 exempt		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 300% Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: B to 400% Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: B to 600% Voluntary	
Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
<i>ESI*</i>	10,506	61.1%	10,117	58.8%	9,923	57.7%	9,908	57.6%	9,620	55.9%	9,519	55.4%
<i>Non-Group*</i>	248	1.4%	433	2.5%	686	4.0%	748	4.3%	1,060	6.2%	1,234	7.2%
<i>Medicaid/CHIP</i>	3,674	21.4%	4,511	26.2%	4,588	26.7%	4,598	26.7%	4,663	27.1%	4,657	27.1%
<i>Other**</i>	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%
<i>Uninsured</i>	2,711	15.8%	2,078	12.1%	1,942	11.3%	1,886	11.0%	1,796	10.4%	1,730	10.1%
<i>Difference***</i>												
<i>ESI*</i>	-	-	-388	-2.3%	-582	-3.4%	-598	-3.5%	-885	-5.1%	-987	-5.7%
<i>Non-Group*</i>	-	-	184	1.1%	437	2.5%	499	2.9%	812	4.7%	986	5.7%
<i>Medicaid/CHIP</i>	-	-	837	4.9%	914	5.3%	924	5.4%	989	5.7%	983	5.7%
<i>Uninsured</i>	-	-	-633	-3.7%	-769	-4.5%	-825	-4.8%	-915	-5.3%	-982	-5.7%
% decline in uninsured		-		-23.4%		-28.4%		-30.4%		-33.8%		-36.2%
% covered or eligible for public		-		94.4%		95.0%		95.3%		95.8%		96.2%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Those with Medicare coverage are excluded from this table.

* For post-reform coverage in Models 1-6 through 1-16, those buying coverage through the purchasing pool are included in Non-Group coverage if buying as individuals and in ESI if buying through an employer.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

** There is no change in other public coverage between baseline and reform

*** Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results
Summary Table 2B
Health Care Spending**

Model	1-6	1-7	1-8	1-9	1-10
Description (see notes for more detail) (in millions, 2009 \$)	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Employer assessment varies, under 50 exempt	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 300% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 600% Voluntary
Total Government Spending (federal + state)					
<i>a. Baseline</i>	\$28,545	\$28,545	\$28,545	\$28,545	\$28,545
<i>b. Gross Post-Reform</i>	\$31,001	\$32,902	\$33,177	\$35,928	\$36,676
<i>c. Empl. Assess. if app.</i>	\$496	\$0	\$0	\$0	\$0
<i>d. b-c</i>	\$30,505	\$32,902	\$33,177	\$35,928	\$36,676
<i>e. Net Chng Post Reform</i>	\$1,960	\$4,357	\$4,632	\$7,383	\$8,131
<i>f. % Chng Post Reform</i>	6.9%	15.3%	16.2%	25.9%	28.5%
<i>g. Net Govt Cost/Newly Insured</i>	\$3,878	\$5,664	\$5,612	\$8,066	\$8,283
<i>h. Net Govt Cost/Newly Insured, Post Assessment</i>	\$3,094	n/a	n/a	n/a	n/a
Employer Spending					
<i>i. Baseline</i>	\$33,321	\$33,321	\$33,321	\$33,321	\$33,321
<i>j. Post-Reform</i>	\$31,896	\$31,305	\$31,008	\$30,294	\$30,485
<i>k. Empl. Assess. if app.</i>	\$496	\$0	\$0	\$0	\$0
<i>l. j+k</i>	\$32,392	\$31,305	\$31,008	\$30,294	\$30,485
<i>m. Net Chng Post Reform</i>	-\$929	-\$2,016	-\$2,313	-\$3,027	-\$2,836
<i>n. % Chng Post Reform</i>	-2.8%	-6.1%	-6.9%	-9.1%	-8.5%
Individual Spending					
<i>o. Baseline</i>	\$22,033	\$22,033	\$22,033	\$22,033	\$22,033
<i>p. Post-Reform</i>	\$21,650	\$23,111	\$23,385	\$24,758	\$25,715
<i>q. Government Subs. if app.</i>	\$0	\$1,720	\$1,968	\$4,611	\$5,423
<i>r. p-q</i>	\$21,650	\$21,391	\$21,417	\$20,147	\$20,292
<i>s. Net Chng Post Reform</i>	-\$383	-\$642	-\$616	-\$1,886	-\$1,741
<i>t. <200% of the federal poverty level</i>	-\$1,107	-\$1,143	-\$1,151	-\$1,174	-\$1,150
<i>u. 200-399% of the federal poverty level</i>	\$438	\$255	\$346	-\$859	-\$832
<i>v. 400%+ of the federal poverty level</i>	\$286	\$246	\$189	\$146	\$240
<i>w. % Chng Post Reform</i>	-1.7%	-2.9%	-2.8%	-8.6%	-7.9%
Aggregate Change (e+m+s)					
	\$647	\$1,698	\$1,702	\$2,469	\$3,554

Source: Urban Institute analysis, HIPSM 2009.

Notes: Base government spending includes acute care for the non-elderly population. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. n/a stands for not applicable. Uncompensated care costs and how they change under the different policy options are not reported.

Line g is calculated by subtracting line b from line a, then dividing by the number of newly insured. Line h is calculated by subtracting line a from line d, then dividing by the number of newly insured.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 3B
Share of Employees with Employer Sponsored Insurance Offers, by Firm Size**

Model	0	1-6	1-7	1-8	1-9	1-10
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Employer assessment varies, under 50 exempt	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 300% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 600% Voluntary
Post-Reform Offer						
<i>Small Firms</i>	63.1%	56.1%	56.9%	57.3%	58.1%	58.4%
<i>Large Firms</i>	92.0%	91.6%	90.4%	90.3%	89.9%	89.7%
<i>Overall</i>	82.7%	80.3%	79.7%	79.8%	79.7%	79.7%
Difference*						
<i>Small Firms</i>	-	-7.1%	-6.2%	-5.8%	-5.0%	-4.7%
<i>Large Firms</i>	-	-0.3%	-1.6%	-1.6%	-2.1%	-2.3%
<i>Overall</i>	-	-2.5%	-3.1%	-3.0%	-3.0%	-3.0%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

* Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 4B
Health Insurance Premiums, by Firm Size**

Model	0	1-6	1-7	1-8	1-9	1-10
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Employer assessment varies, under 50 exempt	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 300% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 400% Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: B to 600% Voluntary
Average Post-Reform Employer-Sponsored Insurance Premiums (in 2009\$)						
<i>Small Firms</i>						
<i>Single</i>	\$5,994	\$5,390	\$5,353	\$5,371	\$5,285	\$5,356
<i>Family</i>	\$15,253	\$15,406	\$13,815	\$13,494	\$13,326	\$13,303
<i>Large Firms</i>						
<i>Single</i>	\$5,240	\$5,305	\$5,366	\$5,329	\$5,313	\$5,408
<i>Family</i>	\$13,408	\$13,573	\$13,729	\$13,634	\$13,594	\$13,836
Difference						
<i>Small Firms</i>						
<i>Single</i>	-	-\$604	-\$641	-\$622	-\$709	-\$637
<i>Family</i>	-	\$152	-\$1,438	-\$1,759	-\$1,927	-\$1,950
<i>Large Firms</i>						
<i>Single</i>	-	\$65	\$126	\$88	\$73	\$168
<i>Family</i>	-	\$166	\$322	\$226	\$186	\$429
Post-Reform Private Non-Group Insurance Premiums (in 2009\$)						
<i>Single</i>	\$11,644	\$5,118	\$5,070	\$5,094	\$4,977	\$5,061
<i>Family</i>	\$26,183	\$15,002	\$13,128	\$12,764	\$12,527	\$12,500
Difference						
<i>Single</i>	-	-\$6,526	-\$6,573	-\$6,549	-\$6,667	-\$6,583
<i>Family</i>	-	-\$11,182	-\$13,056	-\$13,419	-\$13,657	-\$13,684

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Standardized private non-group premiums in the baseline are compared to premiums in the post-reform non-group market.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 1C
Health Insurance Coverage**

Model	0		1-11		1-12		1-13		1-14		1-15	
Description (see notes for more detail)	Baseline		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Individual Mandate		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 25 exempt Voluntary		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 50 exempt Voluntary	
Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
ESI*	10,506	61.1%	10,466	60.9%	9,927	57.7%	9,883	57.5%	9,856	57.3%	9,838	57.2%
Non-Group*	248	1.4%	1,108	6.4%	827	4.8%	837	4.9%	844	4.9%	853	5.0%
Medicaid/CHIP	3,674	21.4%	5,566	32.4%	4,573	26.6%	4,584	26.7%	4,594	26.7%	4,596	26.7%
Other**	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%
Uninsured	2,711	15.8%	0	0.0%	1,813	10.5%	1,836	10.7%	1,846	10.7%	1,853	10.8%
<i>Difference***</i>												
ESI*	-	-	-40	-0.2%	-579	-3.4%	-622	-3.6%	-650	-3.8%	-667	-3.9%
Non-Group*	-	-	859	5.0%	578	3.4%	589	3.4%	596	3.5%	604	3.5%
Medicaid/CHIP	-	-	1,892	11.0%	899	5.2%	909	5.3%	920	5.3%	922	5.4%
Uninsured	-	-	-2,711	-15.8%	-898	-5.2%	-876	-5.1%	-866	-5.0%	-859	-5.0%
% decline in uninsured	-	-	-100.0%		-33.1%		-32.3%		-31.9%		-31.7%	
% covered or eligible for public	-	-	100.0%		95.7%		95.5%		95.5%		95.5%	

Source: Urban Institute analysis, HIPSM 2009.

Note: Those with Medicare coverage are excluded from this table.

* For post-reform coverage in Models 1-6 through 1-16, those buying coverage through the purchasing pool are included in Non-Group coverage if buying as individuals and in ESI if buying through an employer.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

** There is no change in other public coverage between baseline and reform

*** Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 2C
Health Care Spending**

Model	1-11	1-12	1-13	1-14	1-15
Description (see notes for more detail) (in millions, 2009 \$)	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Individual Mandate	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Voluntary	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Voluntary	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 25 exempt Voluntary	Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 50 exempt Voluntary
Total Government Spending (federal + state)					
<i>a. Baseline</i>	\$28,545	\$28,545	\$28,545	\$28,545	\$28,545
<i>b. Gross Post-Reform</i>	\$35,691	\$33,972	\$33,906	\$33,917	\$33,911
<i>c. Empl. Assess. if app.</i>	\$0	\$1,499	\$900	\$611	\$517
<i>d. b-c</i>	\$35,691	\$32,473	\$33,006	\$33,306	\$33,394
<i>e. Net Chng Post Reform</i>	\$7,146	\$3,928	\$4,461	\$4,761	\$4,849
<i>f. % Chng Post Reform</i>	25.0%	13.8%	15.6%	16.7%	17.0%
<i>g. Net Govt Cost/Newly Insured</i>	\$2,635	\$6,044	\$6,121	\$6,206	\$6,250
<i>h. Net Govt Cost/Newly Insured, Post Assessment</i>	n/a	\$4,374	\$5,094	\$5,500	\$5,648
Employer Spending					
<i>i. Baseline</i>	\$33,321	\$33,321	\$33,321	\$33,321	\$33,321
<i>j. Post-Reform</i>	\$31,724	\$30,919	\$30,759	\$30,845	\$30,766
<i>k. Empl. Assess. if app.</i>	\$0	\$1,499	\$900	\$611	\$517
<i>l. j+k</i>	\$31,724	\$32,418	\$31,659	\$31,456	\$31,283
<i>m. Net Chng Post Reform</i>	-\$1,597	-\$903	-\$1,662	-\$1,865	-\$2,038
<i>n. % Chng Post Reform</i>	-4.8%	-2.7%	-5.0%	-5.6%	-6.1%
Individual Spending					
<i>o. Baseline</i>	\$22,033	\$22,033	\$22,033	\$22,033	\$22,033
<i>p. Post-Reform</i>	\$24,593	\$23,798	\$23,811	\$23,868	\$23,879
<i>q. Government Subs. if app.</i>	\$2,244	\$2,869	\$2,773	\$2,719	\$2,710
<i>r. p-q</i>	\$22,349	\$20,928	\$21,038	\$21,148	\$21,169
<i>s. Net Chng Post Reform</i>	\$316	-\$1,105	-\$995	-\$885	-\$864
<i>t. <200% of the federal poverty level</i>	-\$1,579	-\$1,116	-\$1,128	-\$1,137	-\$1,139
<i>u. 200-399% of the federal poverty level</i>	\$1,051	\$50	\$130	\$200	\$218
<i>v. 400%+ of the federal poverty level</i>	\$845	-\$38	\$3	\$52	\$57
<i>w. % Chng Post Reform</i>	1.4%	-5.0%	-4.5%	-4.0%	-3.9%
Aggregate Change (e+m+s)	\$5,865	\$1,920	\$1,804	\$2,011	\$1,947

Source: Urban Institute analysis, HIPSM 2009.

Notes: Base government spending includes acute care for the non-elderly population. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. n/a stands for not applicable. Uncompensated care costs and how they change under the different policy options are not reported.

Line g is calculated by subtracting line b from line a, then dividing by the number of newly insured. Line h is calculated by subtracting line a from line d, then dividing by the number of newly insured.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below). Uncompensated care costs and how they change under the different policy options are not reflected in the table.

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 3C
Share of Employees with Employer Sponsored Insurance Offers, by Firm Size**

Model	0	1-11	1-12	1-13	1-14	1-15
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400%	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 25 exempt	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 50 exempt
		Individual Mandate	Voluntary	Voluntary	Voluntary	Voluntary
Post-Reform Offer						
<i>Small Firms</i>	63.1%	61.2%	60.1%	58.7%	57.7%	57.2%
<i>Large Firms</i>	92.0%	91.8%	91.3%	91.3%	91.3%	91.3%
<i>Overall</i>	82.7%	82.0%	81.3%	80.9%	80.6%	80.4%
Difference*						
<i>Small Firms</i>	-	-1.9%	-3.0%	-4.4%	-5.4%	-5.9%
<i>Large Firms</i>	-	-0.2%	-0.6%	-0.6%	-0.6%	-0.6%
<i>Overall</i>	-	-0.7%	-1.4%	-1.8%	-2.1%	-2.3%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

* Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 4C
Health Insurance Premiums, by Firm Size**

Model	0	1-11	1-12	1-13	1-14	1-15
Description (see notes for more detail)	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Individual Mandate	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment exempt Voluntary	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment exempt Voluntary
Average Post-Reform Employer-Sponsored Insurance Premiums (in 2009\$)						
<i>Small Firms</i>						
<i>Single</i>	\$5,994	\$5,037	\$5,354	\$5,332	\$5,369	\$5,359
<i>Family</i>	\$15,253	\$13,117	\$13,436	\$13,464	\$13,519	\$13,536
<i>Large Firms</i>						
<i>Single</i>	\$5,240	\$5,078	\$5,326	\$5,333	\$5,370	\$5,366
<i>Family</i>	\$13,408	\$12,991	\$13,630	\$13,646	\$13,742	\$13,730
Difference						
<i>Small Firms</i>						
<i>Single</i>	-	-\$957	-\$640	-\$661	-\$625	-\$634
<i>Family</i>	-	-\$2,137	-\$1,818	-\$1,790	-\$1,734	-\$1,717
<i>Large Firms</i>						
<i>Single</i>	-	-\$163	\$86	\$93	\$130	\$126
<i>Family</i>	-	-\$416	\$222	\$238	\$335	\$323
Post-Reform Private Non-Group Insurance Premiums (in 2009\$)						
<i>Single</i>	\$11,644	\$4,723	\$5,085	\$5,059	\$5,088	\$5,074
<i>Family</i>	\$26,183	\$12,402	\$12,746	\$12,760	\$12,793	\$12,798
Difference						
<i>Single</i>	-	-\$6,920	-\$6,559	-\$6,584	-\$6,555	-\$6,570
<i>Family</i>	-	-\$13,781	-\$13,437	-\$13,423	-\$13,391	-\$13,386

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Standardized private non-group premiums in the baseline are compared to premiums in the post-reform non-group market.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 1D
Health Insurance Coverage**

Model	0		1-16		1-17		1-18		2-1		3-1		4-1	
Description (see notes for more detail)	Baseline		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Individual Mandate		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate		Public Expansion: Children to 400% Adults to 200% Merge < 50 w/NG; Public plan Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate		Public Health Insurance for All Maintains current Medicaid/CHIP Fully publicly financed First-dollar coverage Automatic Enrollment		NY Health Plus Plan Maintains current Medicaid/CHIP All eligible for Family Health Plus 10% Employer assessment Automatic Enrollment		Modified "Freedom" Plan Maintains current Medicaid/CHIP NG: HDHP option, limited rating < 50 and NG: Subsidies and addnl gov't reinsurance	
Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
ESI*	10,506	61.1%	10,355	60.2%	10,338	60.1%	10,335	60.1%	0	0.0%	4,327	25.3%	10,479	60.9%
Non-Group*	248	1.4%	1,222	7.1%	1,230	7.2%	1,232	7.2%	0	0.0%	0	0.0%	635	3.7%
Medicaid/CHIP	3,674	21.4%	5,563	32.4%	5,572	32.4%	5,573	32.4%	6,086	35.4%	5,394	31.4%	3,730	21.7%
Other**	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%	55	0.3%
Uninsured	2,711	15.8%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2,295	13.3%
Public for All	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	11,054	64.3%	n/a	n/a	n/a	n/a
New FHP	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	7,418	43.0%	n/a	n/a
Difference***														
ESI*	-	-	-150	-0.9%	-168	-1.0%	-170	-1.0%	-10,506	-61.1%	-6,178	-35.8%	-27	-0.2%
Non-Group*	-	-	973	5.7%	981	5.7%	984	5.7%	-248	-1.4%	-248	-1.4%	387	2.3%
Medicaid/CHIP	-	-	1,889	11.0%	1,898	11.0%	1,898	11.0%	2,412	14.0%	1,720	10.0%	56	0.3%
Uninsured	-	-	-2,711	-15.8%	-2,711	-15.8%	-2,711	-15.8%	-2,711	-15.8%	-2,711	-15.8%	-416	-2.4%
Public for All	-	-	n/a	n/a	n/a	n/a	n/a	n/a	11,054	56.9%	n/a	n/a	n/a	n/a
New FHP	-	-	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	7,418	38.1%	n/a	n/a
% decline in uninsured	-	-	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-15.4%	-15.4%
% covered or eligible for public	-	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.6%	92.6%

Source: Urban Institute analysis, HIPSM 2009.

Note: Those with Medicare coverage are excluded from this table. n/a stand for not applicable.

* For post-reform coverage in Models 1-6 through 1-16, those buying coverage through the purchasing pool are included in Non-Group coverage if buying as individuals and in ESI if buying through an employer.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%

200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%

250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment

60,000+: 6% assessment

** There is no change in other public coverage between baseline and reform

*** Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 2D
Health Care Spending**

Model	1-16	1-17	1-18	2-1	3-1	4-1
Description (see notes for more detail) (in millions, 2009 \$)	Public Expansion: <i>Children to 400% Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Individual Mandate	Public Expansion: <i>Children to 400% Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate	Public Expansion: <i>Children to 400% Adults to 200%</i> Merge < 50 w/NG; Public plan Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate	Public Health Insurance for Maintains current Medicaid/CHIP Fully publicly financed First-dollar coverage Automatic Enrollment	NY Health Plus Plan Maintains current Medicaid/CHIP All eligible for Family Health Plus 10% Employer assessment Automatic Enrollment	Modified "Freedom" Plan Maintains current Medicaid/CHIP NG: HDHP option, limited rating < 50 and NG: Subsidies addn'l gov't reinsurance
Total Government Spending (federal + state)						
<i>a. Baseline</i>	\$28,545	\$28,545	\$28,545	\$28,545	\$28,545	\$28,545
<i>b. Gross Post-Reform</i>	\$36,694	\$36,568	\$36,478	\$86,265	\$76,028	\$31,294
<i>c. Empl. Assess. if app.</i>	\$1,350	\$803	\$803	\$0	\$13,568	\$0
<i>d. b-c</i>	\$35,344	\$35,765	\$35,675	\$86,265	\$62,460	\$31,294
<i>e. Net Chng Post Reform</i>	\$6,799	\$7,220	\$7,130	\$57,720	\$33,915	\$2,749
<i>f. % Chng Post Reform</i>	23.8%	25.3%	25.0%	202.2%	118.8%	9.6%
<i>g. Net Govt Cost/Newly Insured</i>	\$3,005	\$2,959	\$2,926	\$21,287	\$17,512	\$6,605
<i>h. Net Govt Cost/Newly Insured, Post Assessment</i>	\$2,507	\$2,663	\$2,630	n/a	\$12,508	n/a
Employer Spending						
<i>i. Baseline</i>	\$33,321	\$33,321	\$33,321	\$33,321	\$33,321	\$33,321
<i>j. Post-Reform</i>	\$31,329	\$31,349	\$31,121	\$0	\$9,834	\$31,250
<i>k. Empl. Assess. if app.</i>	\$1,350	\$803	\$803	\$0	\$13,568	\$0
<i>l. j+k</i>	\$32,680	\$32,152	\$31,924	\$0	\$23,402	\$31,250
<i>m. Net Chng Post Reform</i>	-\$642	-\$1,169	-\$1,397	-\$33,321	-\$9,920	-\$2,071
<i>n. % Chng Post Reform</i>	-1.9%	-3.5%	-4.2%	-100.0%	-29.8%	-6.2%
Individual Spending						
<i>o. Baseline</i>	\$22,033	\$22,033	\$22,033	\$22,033	\$22,033	\$22,033
<i>p. Post-Reform</i>	\$25,055	\$25,084	\$24,907	\$0	\$4,109	\$23,866
<i>q. Government Subs. if app.</i>	\$3,234	\$3,101	\$3,011	\$0	\$0	\$645
<i>r. p-q</i>	\$21,821	\$21,983	\$21,895	\$0	\$4,109	\$23,220
<i>s. Net Chng Post Reform</i>	-\$212	-\$50	-\$138	-\$22,033	-\$17,924	\$1,187
<i>t. <200% of the federal poverty level</i>	-\$1,562	-\$1,566	-\$1,605	-\$3,936	-\$3,106	\$72
<i>u. 200-399% of the federal poverty level</i>	\$724	\$831	\$803	-\$6,292	-\$5,031	\$686
<i>v. 400%+ of the federal poverty level</i>	\$627	\$686	\$666	-\$11,805	-\$9,787	\$428
<i>w. % Chng Post Reform</i>	-1.0%	-0.2%	-0.6%	-100.0%	-81.3%	5.4%
Unmet Demand	n/a	n/a	n/a	\$402	\$1,032	n/a
Aggregate Change (e+m+s)	\$5,945	\$6,001	\$5,596	\$2,365	\$6,072	\$1,865

Source: Urban Institute analysis, HIPSM 2009.

Notes: Base government spending includes acute care for the non-elderly population. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. n/a stands for not applicable. Uncompensated care costs and how they change under the different policy options are not reported.

Line g is calculated by subtracting line b from line a, then dividing by the number of newly insured. Line h is calculated by subtracting line a from line d, then dividing by the number of newly insured.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 3D
Share of Employees with Employer Sponsored Insurance Offers, by Firm Size**

Model	0	1-16	1-17	1-18	2-1	3-1	4-1
Description <small>(see notes for more detail)</small>	Baseline	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, no exemptions Individual Mandate	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG; Public plan Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate	Public Health Insurance for All Maintains current Medicaid/CHIP Fully publicly financed First-dollar coverage Automatic Enrollment	NY Health Plus Plan Maintains current Medicaid/CHIP All eligible for Family Health Plus 10% Employer assessment Automatic Enrollment	Modified "Freedom" Plan Maintains current Medicaid/CHIP NG: HDHP option, limited rating < 50 and NG: Subsidies and addnl gov't reinsurance
Post-Reform Offer							
<i>Small Firms</i>	63.1%	62.2%	61.6%	61.6%	0.0%	31.2%	74.3%
<i>Large Firms</i>	92.0%	91.9%	91.9%	91.9%	0.0%	64.8%	89.8%
<i>Overall</i>	82.7%	82.4%	82.2%	82.2%	0.0%	54.0%	84.8%
Difference*							
<i>Small Firms</i>	-	-0.9%	-1.5%	-1.5%	-63.1%	-32.0%	11.2%
<i>Large Firms</i>	-	-0.1%	-0.1%	-0.1%	-92.0%	-27.1%	-2.2%
<i>Overall</i>	-	-0.3%	-0.5%	-0.5%	-82.7%	-28.7%	2.1%

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Subsidy Schedule B:

Below 160%: no cost
160 - 224%: individuals 1.4%, families 1.6%
225 - 249%: individuals 1.6%, families 2%
250 - 299%: individuals 2.4%, families 2.9%
300 - 349%: individuals 2.8%, families 3.4%
350 - 399%: individuals 3.5%, families 4.1%
400 - 499%: individuals 4.3%, families 5.1%
500 - 599%: individuals 4.7%, families 5.8%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

* Difference shows the percentage-point change in coverage relative to baseline

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 4D
Health Insurance Premiums, by Firm Size**

Model	0	1-16	1-17	1-18	2-1	3-1	4-1
Description <small>(see notes for more detail)</small>	Baseline	Public Expansion: <i>Children to 400% Adults to 200%</i>	Public Expansion: <i>Children to 400% Adults to 200%</i>	Public Expansion: <i>Children to 400% Adults to 200%</i>	Public Health Insurance for All Maintains current Medicaid/CHIP	NY Health Plus Plan Maintains current Medicaid/CHIP	Modified "Freedom" Plan Maintains current Medicaid/CHIP
		Merge < 50 w/NG	Merge < 50 w/NG	Merge < 50 w/NG; Public plan	Fully publicly financed	All eligible for Family Health Plus	NG: HDHP option, limited rating
		Subsidies: A to 400%	Subsidies: A to 400%	Subsidies: A to 400%	First-dollar coverage	10% Employer assessment	
		Employer assessment varies, no exemptions	Employer assessment varies, under 10 exempt	Employer assessment varies, under 10 exempt			< 50 and NG: Subsidies and addn'l gov't reinsurance
		Individual Mandate	Individual Mandate	Individual Mandate	Automatic Enrollment	Automatic Enrollment	
Average Post-Reform Employer-Sponsored Insurance Premiums (in 2009\$)							
<i>Small Firms</i>							
<i>Single</i>	\$5,994	\$5,082	\$5,067	\$5,042	n/a	\$4,443	\$5,882
<i>Family</i>	\$15,253	\$13,189	\$13,194	\$13,128	n/a	\$12,324	\$14,996
<i>Large Firms</i>							
<i>Single</i>	\$5,240	\$5,100	\$5,125	\$5,120	n/a	\$3,785	\$5,151
<i>Family</i>	\$13,408	\$13,049	\$13,113	\$13,103	n/a	\$10,599	\$13,181
Difference							
<i>Small Firms</i>	-						
<i>Single</i>	-	-\$912	-\$927	-\$952	n/a	-\$724	-\$112
<i>Family</i>	-	-\$2,064	-\$2,059	-\$2,125	n/a	-\$2,066	-\$257
<i>Large Firms</i>	-						
<i>Single</i>	-	-\$140	-\$115	-\$120	n/a	-\$732	-\$89
<i>Family</i>	-	-\$359	-\$294	-\$304	n/a	-\$2,049	-\$227
Post-Reform Private Non-Group Insurance Premiums (in 2009\$)							
<i>Single</i>	\$11,644	\$4,730	\$4,705	\$4,678	n/a	\$4,019	\$4,772
<i>Family</i>	\$26,183	\$12,431	\$12,403	\$12,334	n/a	n/a	\$13,386
Difference							
<i>Single</i>		-\$6,914	-\$6,938	-\$6,965	n/a	-\$7,625	-\$6,872
<i>Family</i>		-\$13,752	-\$13,781	-\$13,850	n/a	n/a	-\$12,798

Source: Urban Institute analysis, HIPSM 2009.

Notes: Small firms are those with up to 50 employees; large firms have 50 or more employees. n/a stand for not applicable.

Standardized private non-group premiums in the baseline are compared to premiums in the post-reform non-group market.

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):

Below 20,000: 2% assessment

20,000 - 60,000: 4% assessment

60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 5
5 and 10 Year Projections
Post-Reform Health Insurance Coverage**

Model	1-3						1-17					
Description <small>(see notes for more detail)</small>	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG Voluntary						Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG; Public plan Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate					
	2009		2014		2019		2009		2014		2019	
Post-Reform Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
<i>ESI</i>	10,062	58.5%	9,897	58.1%	9,754	58.0%	10,338	60.1%	10,189	59.8%	10,057	59.8%
<i>Non-Group</i>	449	2.6%	361	2.1%	313	1.9%	1,230	7.2%	1,089	6.4%	1,097	6.5%
<i>Medicaid/CHIP</i>	4,523	26.3%	4,835	28.4%	4,871	28.9%	5,572	32.4%	5,699	33.5%	5,619	33.4%
<i>Other</i>	55	0.3%	56	0.3%	56	0.3%	55	0.3%	56	0.3%	56	0.3%
<i>Uninsured</i>	2,105	12.2%	1,884	11.1%	1,836	10.9%	0	0.0%	0	0.0%	0	0.0%
	17,195	0,000	17,033		16,829		17,195		17,033		16,829	

Source: Urban Institute analysis, HIPSIM 2009.

Note: Those with Medicare coverage are excluded from this table.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Employer Assessment Schedule. Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 6
5 and 10 Year Projections
Post-Reform Health Care Spending**

Model	1-3			1-17		
Description (see notes for more detail)	Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/ NG Voluntary			Public Expansion: <i>Children to 400%</i> <i>Adults to 200%</i> Merge < 50 w/NG; Public plan Subsidies: A to 400% Employer assessment varies, under 10 exempt Individual Mandate		
(in millions of nominal dollars for each year)	2009	2014	2019	2009	2014	2019
Total Government Spending (federal + state)						
<i>a. Gross Post-Reform</i>	\$31,025	\$41,039	\$52,292	\$36,568	\$48,782	\$64,538
<i>b. Empl. Assess. if app.</i>	\$0	\$0	\$0	\$803	\$956	\$1,166
<i>c. b-c</i>	\$31,025	\$41,039	\$26,431	\$35,765	\$47,826	\$63,372
Employer Spending						
<i>d. Post-Reform</i>	\$31,806	\$41,270	\$55,362	\$31,349	\$38,559	\$47,004
<i>e. Empl. Assess. if app.</i>	\$0	\$0	\$0	\$803	\$956	\$1,072
<i>f. e+f</i>	\$31,806	\$41,270	\$55,362	\$32,152	\$39,515	\$48,076
Individual Spending						
<i>g. Post-Reform</i>	\$21,712	\$26,907	\$34,803	\$25,084	\$37,099	\$55,500
<i>h. Government Subs.</i>	\$0	\$0	\$0	\$3,101	\$5,377	\$9,980
<i>j. h-i</i>	\$21,712	\$26,907	\$34,803	\$21,983	\$31,722	\$45,520

Source: Urban Institute analysis, HIPSM 2009.

Note: Those with Medicare coverage are excluded from this table. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. Uncompensated care costs and how they change under the different policy options are not reported.

Subsidies are available for those in the income eligibility range (see schedules below) and who purchase coverage through the non-group/small-group purchasing pool.

Employer assessments are offset dollar-for-dollar by contributions that employers make to health insurance premiums for their employees. Assessments vary by wage of the employee (see schedule below).

Subsidy Schedule A:

Below 160%: no cost
160 - 179%: 2%
180 - 199%: 4%
200 - 249%: 6%
250 - 299%: 8%
300 - 349%: 10%
350 - 399%: 12%

Employer Assessment Schedule, Varying by Employee Wage:

Employee wage (\$):
Below 20,000: 2% assessment
20,000 - 60,000: 4% assessment
60,000+: 6% assessment

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 7
5 and 10 Year Projections
Post-Reform Health Insurance Coverage**

Model	2-1						3-1					
	Public Health Insurance for All <i>Maintains Current Medicaid/CHIP</i>						NY Health Plus Plan <i>Maintains Current Medicaid/CHIP</i>					
Description (see notes for more detail)	Fully publicly financed First-dollar coverage Automatic Enrollment						All eligible for Family Health Plus 10% Employer Assessment Automatic Enrollment					
	2009		2014		2019		2009		2014		2019	
Post-Reform Coverage (thousands, %)	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%	thousands	%
<i>ESI</i>	0	0.0%	0	0.0%	0	0.0%	4,348	25.3%	3,918	23.0%	3,480	20.7%
<i>Non-Group</i>	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
<i>Medicaid/CHIP, Public for All, new FHP</i>	17,140	99.7%	16,977	99.7%	16,774	99.7%	12,791	74.4%	13,059	76.7%	13,293	79.0%
<i>Other</i>	55	0.3%	56	0.3%	56	0.3%	55	0.3%	56	0.3%	56	0.3%
<i>Uninsured</i>	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Source: Urban Institute analysis, HIPSIM 2009.

Note: Those with Medicare coverage are excluded from this table.

**New York Specific
Health Insurance Reform Simulation Model Results**

**Summary Table 8
5 and 10 Year Projections
Post-Reform Health Care Spending**

Model	2-1			3-1		
Description (see notes for more detail)	Public Health Insurance for All <i>Maintains Current Medicaid/CHIP</i>			NY Health Plus Plan <i>Maintains Current Medicaid/CHIP</i>		
	Fully publicly financed First-dollars coverage Automatic Enrollment			All eligible for Family Health Plus 10% Employer Assessment Automatic Enrollment		
<i>(in millions of nominal dollars for each year)</i>	2009	2014	2019	2009	2014	2019
Total Government Spending (federal + state)						
<i>a. Gross Post-Reform</i>	\$86,265	\$108,464	\$130,287	\$76,028	\$99,986	\$127,078
<i>b. Empl. Assess. if app.</i>	\$0	\$0	\$0	\$13,568	\$15,771	\$20,910
<i>c. b-c</i>	\$86,265	\$108,464	\$130,287	\$62,460	\$84,215	\$106,168
Employer Spending						
<i>d. Post-Reform</i>	\$0	\$0	\$0	\$9,834	\$12,746	\$16,005
<i>e. Empl. Assess. If app.</i>	\$0	\$0	\$0	\$13,568	\$15,771	\$20,910
<i>f. e+f</i>	\$0	\$0	\$0	\$23,402	\$28,517	\$36,914
Individual Spending						
<i>g. Post-Reform</i>	\$0	\$0	\$0	\$4,109	\$5,041	\$6,032
<i>h. Government Subs.</i>	\$0	\$0	\$0	\$0	\$0	\$0
<i>j. h-i</i>	\$0	\$0	\$0	\$4,109	\$5,041	\$6,032

Source: Urban Institute analysis, HPSM 2009.

Note: Those with Medicare coverage are excluded from this table. Employer and individual spending is largely for non-elderly population. However, they include some costs for working, privately-insured population over 64. Uncompensated care costs and how they change under the different policy options are not reported.

Appendix 1. The Health Insurance Policy Simulation Model for New York (HIPSM-NY): Construction and Estimation

In this appendix, we describe the construction and estimation of the New York-specific version of the Health Insurance Policy Simulation Model (HIPSM-NY). Developed by Urban Institute researchers, the model predicts the effects of health insurance reform options in New York State. Below, we first describe how we construct the baseline database. We then discuss the theoretical framework and the implementation of the behavioral modules for insurance decision-making, which results in changes in coverage and other outcomes after reform. We follow with a description of the flow of the reform and behavioral modules during a simulated reform.

Baseline Database Construction

Construction of the core file. The core microdata file defining the model's population base for New York State is a matched version of the March 2005 CPS Annual Social and Economic Supplement, the February 2005 CPS Contingent Work and Alternative Employment Supplement, and the 2004 Statistics of Income (SOI) public use tax file. The March CPS is the main source of demographic characteristics and insurance coverage; the February CPS contains information on employer-sponsored insurance (ESI) offers and employee eligibility that is not available in the March file; and the SOI is a stratified random sample of 150,047 unaudited tax returns representative of the population of returns filed for tax year 2004. The SOI file provides detailed information on the forms filed, the income earned, and the tax computed for each record. Wherever possible, we link CPS records across the February and March surveys. For observations in the March CPS without a corresponding observation in the February CPS, we impute

values for health insurance offer and eligibility. We statistically matched observations from the augmented SOI file to the CPS. Health care expenditures, unique health insurance variables, and health conditions from a dataset that pooled 2002-2004 of the Medical Panel Survey (MEPS) were statistically matched to the core file by common characteristics in the two datasets. Health expenditures in the combined file maintain the statistical distributions and relationships with other variables in the original MEPS.

To simulate different health care reforms for New York State, we need the baseline database to represent the state’s unique characteristics while providing a large enough sample to estimate the impacts of detailed reform plans. The sample for New York State in the core file is too small for this purpose. Thus, we use the northeast region of the core file and re-weight the data to reflect New York State’s rates of health insurance and demographic information from the 2006 March CPS (the most recent data available at the time). We then inflate the weights so that the total population matches the Census projections for New York in 2009, preserving the demographic distributions. Further adjustments are made to the baseline file to reflect data provided to us by the State – including the number of non-group enrollees and the number of Healthy New York enrollees. Finally, we “age” the population, income, and health expenditure data to 2009 and present reform results as if reforms are fully implemented in 2009. For two simulations, we age the data to 2014 and 2019.

Medicaid/CHIP eligibility determination and undercount adjustment. To measure Medicaid and Children’s Health Insurance Program (CHIP) eligibility, we used the Urban Institute Health Policy Center eligibility simulation model.³⁶ The model

³⁶ Lisa Dubay, John Holahan, and Allison Cook, “The Uninsured and the Affordability of Health Insurance Coverage,” *Health Affairs*, 26, no. 1 (2007); w22–w30 (published online 30 November 2006).

compares information on family composition, adult employment status, age, earned and unearned income, assets, childcare expenses, employment expenses, and citizenship status to the Medicaid and CHIP eligibility requirements of New York State to determine person-level eligibility status.³⁷ We modify survey weights to compensate for a shortfall in the number of Medicaid and CHIP enrollees reported in the March CPS as compared to the number of enrollees reported by state administrative data.³⁸ Since there is evidence that administrative data overstate and the household surveys understate the number of people with Medicaid or CHIP, we follow a methodology that adjusts the number of Medicaid/CHIP enrollees in the CPS by half of the difference between the CPS survey and the state's administrative data.³⁹ Enrollment targets for adjusting the CPS for the misreporting of public coverage were derived from June 2006 New York State enrollment totals for Medicaid and Family Health Plus.

Creation of synthetic firms. For the purpose of imputing premiums for employer-sponsored coverage and modeling firms' decisions regarding the offer of health insurance coverage, we assign employees in the core file to "synthetic firms." In particular, for each employee, we draw a set of coworkers from the relevant group of observations, classified by region of residence, industry, firm size, and health insurance offering status. The coworkers are drawn such that the distribution of employees in the resulting synthetic firms resembles the underlying distribution in the baseline database

³⁷ Because information about assets and childcare expenses is not collected on the CPS, these values are imputed. In addition, the Medicaid/CHIP eligibility model does not account for documentation status of non-citizens because this information is not available on the CPS. Thus estimates of eligibility may contain some non-citizens who would not qualify for Medicaid or CHIP despite being income- and resource-eligible.

³⁸ See for example, Kathleen Thiede Call, Gestur Davidson, Michael Davern, and Rebecca Nyman, "Medicaid undercount and bias to estimates of uninsurance: new estimates and existing evidence," *Health Services Research* (43:3), June 2008.

³⁹ The methodology assumes that health insurance coverage reported in the March CPS represents a point-in-time estimate.

from which the observations are drawn. The procedure requires replicating workers into multiple firms, and implementing a data-reduction procedure to reduce the size of the dataset while retaining the distribution of employees across firms. Firm weights were constructed to reflect the distribution of firms in New York State, by firm size and industry in 2004, as measured by Statistics of U.S. Business.

Standardizing health care expenditures. Standardized health care expenditures are needed to calculate premiums accurately for individuals purchasing together in the same risk pool. The measures of total and out-of-pocket health expenditures obtained from the MEPS-HC data, however, reflect the particular cost-sharing characteristics of the health insurance benefit package that the surveyed individual/family actually experienced as of the time of the survey. To make spending comparable across the privately insured populations, we define the cost-sharing characteristics (a deductible, a coinsurance rate, and an out-of-pocket maximum) of a standard health plan for both ESI and non-group coverage in New York State (see Table A1-1, below). We then use actuarial induction factors to standardize health expenditures to remove variation attributable to differences in cost-sharing.

Table A1-1. Cost-sharing Characteristics Used in Standardizing Health Expenditures

Standard Benefit Package	Deductible (2009\$)	Coinsurance	Maximum OOP (2009\$)
ESI Benefit Package			
Single	\$400	20%	\$1,990
Family	\$800	20%	\$3,980
Non-group Benefit Package			
Single	\$400	20%	\$1,990
Family	\$800	20%	\$3,980

Effects of coverage on total health care expenditures. To estimate the effects of changes in health insurance coverage on health care expenditures, we analyze the

MEPS-HC data using regression techniques. The resulting effects of coverage on expenditures vary by individual characteristics such as demographic characteristics, socio-economic status and health, and are estimated separately for children and adults. Our estimates are consistent with those from other studies.⁴⁰

Calculation of premiums in employer’s risk pools and the non-group market.

We compute single and family ESI premiums faced by each employee and each firm based on insured expenditures for each firm and an administrative load that varies by firm size, according to a set of rules regulating the rating of ESI premiums in New York State. Our baseline ESI premium estimates compare well to New York premiums reported in the MEPS-IC and other premium estimates available from the state. We compute single and family non-group premiums to reflect insured expenditures of those insured in the non-group market at the baseline, and non-group rating rules of New York State.

New York State assessments and surcharges on health spending and premiums. The calculation of health care spending and premiums also incorporates assessments, surcharges and taxes incurred on certain health services and health insurance premiums in New York State. The New York State Health Care Reform Act (HCRA) legislation imposes varying surcharges on certain health care services for those with ESI, non-group or Medicaid/CHIP coverage,⁴¹ and a regionally varying per capita assessment (known as a “covered lives assessment”) on all ESI or non-group

⁴⁰ Buchmueller, Thomas, Kevin Grumbach, Richard Kronick and James Kahn (2005), “The Effect of Health Insurance on Medical Care Utilization and Implications for Insurance Expansion: a Review of Literature,” *Medical Care Research and Review* 62(1): 3-30.

⁴¹ For payer surcharge rates, see http://www.nyhealth.gov/nysdoh/hcra/docs/payor_surcharge_rates_01-01-06_through_12-31-11.pdf.

enrollment.⁴² In addition, commercial health insurers encounter a 1.75% premium tax and an additional New York State Insurance Department assessment.⁴³

Behavioral Module for Insurance Decisions: Theoretical Framework and Implementation

Modeling demand for insurance options. In order to model individual and family demand for health insurance coverage, we adopt a utility-based approach in which each individual is assigned a “utility value” associated with each health insurance option. Utility values are a measure of the relative desirability of each health insurance option and are expressed in dollars. We model individuals as being in one of four possible insurance coverage states: ESI, non-group coverage, public coverage, or uninsured.⁴⁴ We assign utility values for these insurance options based on an individual’s premiums, expected out-of-pocket payments, risk of high out-of-pocket expenditures, taxes, incomes, and measures of how the individual values health care when insured vs. uninsured, and when coverage is more vs. less comprehensive. Employees convey their valuations of health insurance options to their employers. Employers decide whether to offer their employees coverage based on whether the sum of the employees’ valuations for coverage is greater than its cost, where the cost includes both the total premium for the firm as well as a fixed cost for arranging and administering the coverage.

⁴² For “covered lives assessments” by region, see

http://www.health.state.ny.us/nysdoh/hcra/gme/docs/surcharges_and_assessments_2009.pdf.

⁴³ Details of the additional assessment were communicated to us by the New York State Insurance Department staff.

⁴⁴ Modeling family demand for coverage is complex because multiple combinations of coverage may exist within families, particularly combinations of public and private coverage. We studied ways of simplifying family coverage choices by eliminating combinations of coverage that have low frequency in the CPS. We limit families to one of five configurations of mixed coverage; each of these five family combinations incorporates the family members’ best options within each coverage option when there are multiple choices (for example, if the family has access to multiple private options through ESI and non-group, only their best private option appears in the final choice stage).

The utility values for each individual's health insurance options are paired with an individual-specific error term for each option (less one). There are error terms associated with individual decisions, family decisions, and firm decisions. The error terms account for unobserved preferences for certain types of coverage. We illustrate the importance of these error terms in modeling demand for different health insurance options through the following example. Suppose that the utility values computed for a Medicaid-eligible individual suggest that the individual should have chosen to enroll in Medicaid, but the person is currently uninsured. We add a set of error terms to the individual's utility values for each health insurance option such that the uninsurance option has a larger combined utility value plus error term than any other available option. Under reform, the individual will participate in Medicaid/CHIP if its total value, inclusive of the error term, exceeds the total value of each of the other available options. The magnitudes of behavioral effects in the model (e.g., enrollment rates, responsiveness to changes in premiums) are directly related therefore to the distribution of the error terms.

Calibration of behavioral effects. To reflect the unique characteristics of New York State's health insurance markets, we modified findings from the economic literature to establish targets for the responsiveness of health insurance decisions to changes in premiums. HIPSM-NY was then calibrated so that the responses produced by the model match the targets. These "responses" are often described in the literature as "elasticities." We established targets for 1) non-group premium elasticities, 2) ESI premium elasticities of take-up conditional on firms offering, 3) firm premium elasticities of offering ESI, 4) take-up rates for Medicaid/CHIP coverage of newly eligible individuals. We then calibrate the error terms that relate to particular elasticities and take-up rates so as to meet

our targets. Once we obtain at a set of error terms that meet our targets, they remain fixed across the simulations of different reform scenarios.

Simulating Reforms in HIPSM-NY: Flow of the Reform and Behavioral Modules

Health insurance reforms may alter the set of options available (e.g., by expanding eligibility for public coverage to new groups) or change the relative value of different coverage options (e.g., by providing income-related premium subsidies for an existing option). After a particular reform is introduced in HIPSM-NY, premiums are recalculated, available options are identified, and utility values are recalculated for all options for all individuals and families. Employees' preferences towards ESI therefore change, so employer "costs" of offering coverage are also recalculated. We assume that employee wages will be reduced to offset the costs of offering ESI (i.e., a "wage offset"), thus the size of the wage offsets are also recomputed. Given the net value of offering to the employees (taking the wage offsets into account) and the firm-level error terms, employers decide whether or not to offer given the reforms.

Given these revised decisions, employers, individuals and families then react to their new set of available options. The utility value that each individual and family derives from each option is recalculated. Individuals then choose the option that yields the highest level of utility. The resulting computations in the model reflect revisions to health insurance premiums, medical spending that applies to an individual's new coverage choice, and income taxes. This completes one cycle, or "iteration," in the behavioral flow of the model.

After some employers change their decision to offer coverage and individuals switch to different types of coverage, insurance risk pools change. When the

composition of risk pools change, so must the level of premiums that are required to eliminate excess profits or losses within the insurance market. Premiums are recalculated, thus beginning a new cycle of the behavioral model and potential changes in coverage. The model iterates until coverage is stable across iterations. For practical purposes, we find that the model converges to an acceptable degree with three iterations. We interpret the results after three or more iterations as representing the new long run equilibrium resulting from the reforms.

Appendix 2. Cost Containment Strategies and Modeling Assumptions

Addressing the growth in health care costs through cost containment measures is essential to the success of any of the reform approaches. In this appendix, we first discuss the cost containment assumptions modeled through the reforms simulated in this report. We then present a review of the literature addressing additional cost containment options, and we discuss the extent to which these options could influence health cost growth in New York State. Cost containment strategies discussed in this appendix include: rate setting of physician and hospital fees, health information technology (HIT), prevention, chronic care/disease management and medical homes, malpractice reform, and certificate of need (CON) policies. Cost containment attributable to physician or hospital capacity constraints is discussed in Appendix 3. The modeling incorporates potential cost savings arising from rate setting of physician and hospital fees and capacity constraints only. Although we discuss and provide ranges for the potential cost savings from other strategies in this appendix, such effects are not reflected in the modeling. It is clear that in order to produce overall cost containment for New York, substantial political and financial investment must be made in a combination of cost containment strategies.

Evidence on Cost Savings from Rate Setting of Physician and Hospital Fees

The literature on rate-setting for physician and hospital fees provides fairly strong support for use as a cost containment device, finding that cost growth was lower relative to no rate setting by 3 to 5 percentage points annually with fairly large cumulative effects. However, while rate setting has been effective for periods of several years, its impact seemed to weaken over time. To be successful, it would have to be aggressively pursued and sustained, and people would need to remain cognizant of effects on access and

quality of care. In this section, we discuss the literature pertaining to the impact of rate-setting on costs. We then summarize our assumptions of cost containment stemming from physician and hospital rate-setting for the reform models simulated in this report.

Evidence suggests that a payment reform can be effective in controlling growth over time if private rates to physicians and hospitals are reduced and Medicaid rates are increased to approximately match Medicare rates. The Congressional Budget Office (CBO) issued a report concluding that payment rates for Medicaid and Medicare are lower than those of private payers, but that the difference is much smaller in some areas of the country than others.⁴⁵ The CBO report cites evidence from MedPac that Medicare payment rates for physicians were on average nearly 20 percent lower than private insurance rates in 2006. Medicaid rates for physicians in 2003 were about 30 percent lower than Medicare rates. Data compiled by the American Hospital Association indicates that Medicare's average payment rate for inpatient care were about 30 percent lower than those of private insurers and payments by Medicaid were about 5 percent lower than those of Medicare.⁴⁶

The CBO report found that private rates are much higher than Medicare rates in areas with less competition among providers such as small cities and rural areas. The rate that private insurers are able to negotiate depends to some extent on the relative bargaining power of providers and insurers in local markets. Where there is less competition, private market rates are much higher than Medicare rates. Rates paid to

⁴⁵ The Congressional Budget Office, "Key Issues in Analyzing Major Health Care Proposals." (December 2008). Available at <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf> (accessed 31 March 2009).

⁴⁶ American Hospital Association, "Table 4.4: Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare and Medicaid, 1987 –2007," *Trendwatch Chartbook 2009*, (Spring 2009). <http://www.aha.org/aha/trendwatch/chartbook/2009/appendix4-4.pdf> (accessed 31 March 2009).

physicians by private insurance plans are an average of 30 percent higher than Medicare rates and small metropolitan areas and rural areas 10 percent higher than medium size markets, and 1 percent higher than large metropolitan areas. Proposals that would introduce a state funded public plan would have a bigger impact in rural areas than in larger metropolitan areas.

The CBO report cites evidence that physician provision of services would offset a reduction in physician fees to some degree, but not fully. The report argues that adopting Medicare's current rates would cause a significant reduction in payments for the services provided to physicians. However, this could have adverse consequences if the supply of physicians fall in the areas that experience large reductions in rates and reduce access.

Similarly for hospitals, while lowering rates may create efficiencies, it could cause a significant decline in the financial condition of some hospitals and affect access and the quality of care. The literature seems to suggest a surprising amount of evidence that rate setting has been effective at controlling hospital costs. Evidence of cost containment due to rate-setting is described in Schramm *et al.*, Thorpe, a review by Eby and Cohodes, Morrissey *et al.*, Anderson, Coelen *et al.*, and Sloan.⁴⁷ In light of this evidence, it is somewhat surprising that rate-setting came into disfavor as a cost containment strategy, while arguments for market competition gained support.

⁴⁷ C.J. Schramm, S.C. Renn, B. Biles, "Controlling Hospital Cost Inflation: New perspectives on State Rate Setting," *Health Affairs*, (Fall 1986): 22-33; K. Thorpe, "Does All-Payer Rate Setting Work? The Case of the New York Prospective Hospital Reimbursement Methodology," *Journal of Health Politics, Policy and Law*, (Fall 1987): 391-408; C. Eby, D. Cohodes, "What Do We Know About Rate-Setting," *Journal of Health Politics, Policy and Law*, 10, (1985): 299-328; M. Morrissey, F. Sloan, S. Mitchell, "State Rate-Setting: An Analysis of Some Unresolved Issues," *Health Affairs*, 2, (1983): 36-47; G. Anderson, "All-Payer Rate-Setting: Down but Not Out," *Health Care Financing Review*, (1991 Annual Supplement): 35-41; C. Coelen, D. Sullivan, "An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures," *Health Care Financing Review*, (Winter 1981): 1-40.

Assumptions of Cost Containment Stemming from Physician and Hospital Rate-Setting

In each reform model simulated, we considered the extent to which each reform could alter payment rates and service prices for physicians and hospitals:

Private/Public Plan – For those newly enrolling in Medicaid/CHIP, we assumed that health care spending of those previously insured in the private market will be discounted by a factor to reflect lower payment rates to physicians and hospitals under Medicaid/CHIP and the ability of New York State’s Medicaid/CHIP program to hold down the rate of growth in spending over the long term compared to private insurers.⁴⁸

Overall, this discount is assumed to be 75 percent. In addition, for those enrolling in new plans through an exchange, we assumed that there would be a reduction in baseline costs due to negotiations between the exchange and health insurance plans offered in the exchange. Additional cost savings relative to baseline costs was assumed to be achieved with the addition of a public plan competing with private options in the exchange. In practice, savings from the addition of a public plan in the exchange would depend on the size and strength of the public plan and its effect on market competition, and much of the savings depends on insurer’s bargaining power with providers. Overall, the cost savings from rate-setting assumptions in the public/private reform approaches is estimated to be between that of the cost savings in the Public Health Insurance-for-All reform and Assembly Member Gottfried’s New York Health Plus reform.

⁴⁸ New York State enacted physician fee reform, effective January 1, 2009, in which physician fees increased by approximately 50 percent above previous rates. In addition, the new reform added 10 percent to the fees paid to office-based physicians in Health Professional Shortage Areas (HPSAs). See http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-02.htm#amb. In our simulations, we estimate some cost savings from these reforms, due to an estimated increase in the use of physician services relative to hospital services compared to baseline service use (i.e., more expensive hospital services are substituted with physical services given the rise in physician fees).

Public Health Insurance for All reform – Estimates of cost savings in the single payer system simulated in this report include estimated savings from a decrease in payment rates relative to private rates. These savings are offset somewhat as Medicaid/CHIP rates are assumed to increase to the level of Medicare levels, an increase of approximately 18 percent. For those covered by private insurance at baseline and the new public insurance in reform, this implies that, at least initially, private payments are not reduced to Medicare levels. Over time, we assume that the trend in payments for the new public plan would be below the baseline trend, so that after ten years, health care spending of those in the new public plan would be 10 percent lower than at the baseline, but spending of those with Medicaid/CHIP would be higher.

Assembly Member Gottfried's expanded New York Health Plus plan – This plan would give providers a substantial increase in market power in relation to payers by allowing collective bargaining among physicians. Thus, we judge that this plan would increase payment rates relative to the other reforms simulated in this report. We assume that after 10 years, health care spending of those in the new public plan would be almost 3 percent lower than at the baseline, and we assume that there would be an increase in Medicaid/CHIP rates to Medicare levels.

Evidence on Cost Savings from Health Information Technology (HIT)

New York State's initiative to invest approximately \$250 million in HIT, funded in part by the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY) program, is reported by Kern *et al.*, to be the largest state-level investment in HIT.⁴⁹ By the summer of 2008, approximately one year after funds were released to HIT grantees,

⁴⁹ L.M. Kern, *et al.*, "HEAL NY - Promoting Interoperable Health Information Technology In New York State," *Health Affairs*, 28, no. 2 (2009): 493-504.

35 percent of grantees—typically consisting of a community hospital and associated physician practices—reported having users of the new system. However, the authors find that it is unknown yet whether any cost savings might be achieved from the program.⁵⁰

Overall, based on the evidence on cost savings from the introduction of HIT, we estimate a savings of about 1 to 2 percent of health care spending by the tenth year, assuming it was pursued aggressively with upfront subsidies to support adoption. There would be up front costs that would largely offset savings in the first 3 to 4 years. After that, savings off the baseline would increase to reach 1 to 2 percent after 10 years. Despite the intense interest, savings from the introduction of HIT are no greater than this because of the poor incentives that exist to adopt HIT systems; this stems from the fact that most savings come from reduced duplication in services and tests, fewer hospital admissions, and only some from office efficiencies. This implies that providers would have to bear the cost of HIT adoption and at the same time see lower revenues. Moreover, many of the benefits would result in improved health and may not reduce medical spending but rather postpone it. The following review of the literature supports these conclusions.

The CBO recently reviewed of the evidence on the potential cost savings from HIT.⁵¹ They argue that recent studies suggesting that HIT could potentially provide \$80 billion in savings (about 4 percent of health care costs) may overstate the likely cost savings. CBO is critical of the RAND estimate of \$80 billion in savings in arguing that it

⁵⁰ In addition, Mostashari *et al.* (2009) provide a review of the New York City Primary Care Information Project (PCIP) and find significant barriers to implementation of electronic health records, including large initial investment costs, lost productivity during implementation, and a significant project failure rate.

⁵¹ P. R. Orszag, The Congressional Budget Office, “Evidence on the Costs and Benefits of Health Information Technology,” Testimony Before the Sub-committee on Health, Committee on Ways and Means, U.S. House of Representatives, July 24, 2008.

has measured the potential impact of widespread adoption of IT rather than the likely impact.⁵² They argue that the health care delivery system is now organized in a way that providers are not rewarded for reducing costs. In fact, providers get lower revenues to the extent that fewer services are provided. As of 2006, only 12 percent of physicians and 11 percent of hospitals had adopted some form of electronic health records. As noted by CBO, part of the reason for the low adoption rates is that while providers would bear all of the costs of HIT, they would not reap many of the benefits.⁵³ The CBO review also finds that the RAND study focused on studies that reported positive effects, ignoring those with negative effects, and did not take into account that payment incentives constrain the effective use of HIT, even if the technology is widely adopted. For example, some of the savings from new efficiencies can only be passed on if reimbursement rates are reduced.

The CBO report argues that the incentives to adopt HIT are greatest in relatively integrated health systems. In these systems, reductions in the number of unnecessary office visits, tests, imaging procedures, and so forth benefit providers, health plans, and patients. Thus, it is not surprising that integrated delivery systems including Intermountain Health Care, Partners Health Care, and the VA have been the leaders in the adoption of these technologies. For providers and hospitals that are not part of integrated

⁵² F. Girosi, R. Meili, R. Scoville. "Extrapolating Evidence of Health Information Technology Savings and Costs". RAND Corporation, 2005. A study by the Center for Information Technology Leadership has similar weaknesses to the RAND study. It also estimated \$80 billion in potential savings against a baseline of little or no HIT use, and they make strong assumptions about the savings from eliminating unnecessary lab tests and decreasing prescription medications.

⁵³ The CBO paper provides some data on the cost of implementing health information technology. The estimates seem to be that the cost for office based electronic health record systems would be \$25,000 to \$45,000 per physician with annual operating costs of \$3,000 to 9,000 to maintain the systems. For hospitals, electronic health record systems would cost at least \$14,500 per bed, with annual operating costs of at least \$2,700 per bed.

systems, it is harder to capture the benefits and these physicians and hospitals have been much slower to adopt them.

While the potential for savings, increased efficiency, and improvements in the quality of care may be substantial, the incentives in the current system tilt against achieving many of these benefits. While the CBO argues that \$80 billion or 4 percent is too high an estimate of savings, they do not provide any particular guidance as to what savings could be achieved if there were subsidies to providers to help offset the start-up costs. In addition, they caution that estimating the savings should recognize that many providers will adopt HIT systems without a subsidy policy, thus the savings accruing to the system will only be over and above the baseline trend.

Evidence on Cost Savings from Prevention

The literature on cost savings from disease prevention is mixed. A study by The Lewin Group with funding from the Commonwealth Fund and another by Levi, Segel, and Juliano seem to imply quite a substantial range of estimates on the impact of prevention. The estimates depend on the kind of policy that is being adopted. Aggressive proposals, e.g., taxes on fatty products, may be more effective than more generalized prevention policies. As part of the Bending the Curve project, The Lewin Group made estimates of the impact of reducing obesity prevalence.⁵⁴ They estimated that a policy that adopted a 1 cent tax on soft drinks, restricted the use of trans fats in eating establishments, forced USDA dietary guidelines, and banned sweetened soft drinks from schools would reduce health spending by the tenth year by as much as 1.5 percent if it cut the rate of obesity growth in half. Levi, Segel, and Juliano examined the return on

⁵⁴ C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, "Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending," The Commonwealth Fund, (December 2007).

investment from community level prevention of chronic diseases.⁵⁵ Their work suggests that if programs designed to improve nutrition, increase physical activity, reduce obesity, and reduce the use of tobacco products were 10 percent effective in reducing diabetes and high blood pressure and related diseases, spending could decline by as much as 1.7 percent. A more modest impact of 5 percent effectiveness in the success of these programs would imply savings of up to 0.9 percent.

A study by Russell is much more pessimistic about the effects of prevention. She argues that prevention programs can be quite costly and that unless extremely well targeted, costs can be high and the benefits limited.⁵⁶ Moreover, she maintains that much of the benefit from prevention is in improvement in the quality and length of life and not in reductions in medical spending. A report by the CBO makes many of the same arguments as Russell, but is somewhat more positive, particularly regarding the impact of tax policies.⁵⁷ They cite evidence from studies that show effectiveness of excise taxes and bans in reducing tobacco use; while the studies on obesity prevention are less positive, CBO cites the huge difference in health care spending between obese and normal weight individuals as indicating the potential for savings. But while spending on diseases caused by unhealthy behavior could be reduced, in the long run there are offsetting costs because people live longer and receive Social Security and Medicare benefits for a longer period of time. Overall, these studies suggest that prevention programs could save 1 to 2 percent if aggressively pursued and well targeted.

⁵⁵ Levi J, Segal LM, Juliano C. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. Washington, DC: Trust for America's Health, (July 2008). <http://healthyamericans.org/reports/prevention08/Prevention08.pdf> (accessed 18 September 2008).

⁵⁶ L. B. Russell, "Prevention's Potential for Slowing the Growth of Medical Spending" National Coalition on Health Care, (October 2007).

⁵⁷ The Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," (December 2008), <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf> (accessed 31 March 2009).

Evidence on Cost Savings from Chronic Care/Disease Management and Medical Homes

Evidence on the effects of chronic care management on cost savings is mixed. Several studies show effects on emergency room use and hospitalizations, but much of the research is methodologically flawed⁵⁸ and there are few randomized control studies. A recent review of 317 studies on disease management programs by Mattke, Seid, and Ma reported inconclusive evidence of cost savings from disease management – a finding that is corroborated by a recent report by the CBO.⁵⁹

There is also a growing consensus that a problem with disease management and case management programs is that they have not involved primary care physicians. A major criticism is that these efforts have bypassed physicians. For example, Berenson *et al.* have argued that “medical homes” organized around primary care physicians can improve efficiency in the delivery system and ultimately reduce spending.⁶⁰ Medical homes are intended to give patients ready access to primary care providers who coordinate care provided by specialties hospitals, and laboratories. Primary care physicians would receive a payment for being a medical home.⁶¹ Thus, the savings to medical homes can only occur if they are targeted to patients where they are most likely to achieve savings or if the savings from the reduced use of other services is quite high.

⁵⁸ For example, many studies compare utilization to a base year of spending and thus fail to control for regression to the mean.

⁵⁹ Soeren Mattke, Michael Seid, and Sai Ma, “Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?” *American Journal of Managed Care*, vol. 13, no. 12 (December 2007), pp. 670–676. The Congressional Budget Office, “Key Issues in Analyzing Major Health Insurance Proposals,” (December 2008): 142, <http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf> (accessed 31 March 2009).

⁶⁰ R.A. Berenson, T. Hammons, D.N. Gans, S. Zuckerman, K. Merrell, W.S. Underwood, A.F. Williams, “A House Is Not a Home: Keeping Patients at the Center of Practice Redesign,” *Health Affairs*, 27, no. 5 (2008): 1219-1230.

⁶¹ The AMA has estimated the cost to be about \$650 per beneficiary, which would be a 20 percent increase over current Medicare spending per beneficiary for physician services.

Lewin made estimates of the costs savings from Medicare efforts to strengthen primary care by creating medical homes.⁶² It is estimated that there would be savings of about 0.5 percent to Medicare in the first year after implementation if medical homes were adopted. The savings is estimated to reach 2.3 percent after three years. Much of the savings depends on the offsetting reductions in the use of specialty services or emergency room care; however, providers' financial incentives may interfere with savings. In addition, there may not be an adequate supply of primary care providers to implement medical homes effectively on a broad scale.

The overall effect from chronic care management is likely to be quite small for the non-elderly population, though potentially much greater for the Medicare population. First, most of the non-elderly population does not have serious chronic disease, though about 40 percent of spending for non-elderly adults is for those with asthma, diabetes, or hypertension. Second, the impact of these programs is small—yielding savings of about 3 percent—though savings may be greater for the medical home model. Coupling the small impact with the small percentage of the population who would be enrolled in these kinds of management programs means that the overall effect would be about 1 percent.

Evidence on Cost Savings from Malpractice Reform

Overall, evidence showing the effect of malpractice reform on health care costs indicates that conventional malpractice reform, e.g., caps on damages, may reduce premiums by about 0.5 percent and there would likely be another reduction in spending of approximately 1 percent due to decreases in defensive medicine. However, the extent of cost savings depends on the structure of the reform and on the behavioral responses of

⁶² The Lewin Group, "A Path to a High Performance U.S. Health System: Technical Documentation," (19 February 2009), <http://www.lewin.com/content/publications/4010.pdf> (accessed 31 March 2009).

providers and patients. These estimates of cost savings were drawn from the following literature.

A number of studies have been reviewed by the Office of Technology Assessment and by the CBO. The most common malpractice reforms are caps on economic damages and caps or bans on punitive damages. Thorpe estimates that these reforms may reduce malpractice premiums by more than one-third.⁶³ The CBO estimated that the Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003 would lower malpractice premiums nationwide by an average of 25 to 30 percent, relative to levels likely to occur under current law.⁶⁴ While these impacts are large, the impacts on overall health care costs are small. According to the CBO, malpractice costs amounted to \$24 billion in 2002, less than 2 percent of overall health care spending. Thus, a reduction of 25 to 30 percent in malpractice cost would lower health care costs by only 0.4 to 0.5 percent and would lower health insurance premiums by a similar small amount.

The other potential source of savings from malpractice reform is reductions in defensive medicine, but whether or not savings would be achieved is disputed. A study by Kessler and McClellan examined the effects of states with any of four restrictions (caps on non-economic damages, prohibition on punitive damages, no automatic addition of pre-judgment interest, and offsets for collateral source benefits).⁶⁵ They found a reduction in defensive medicine of about 4 percent. However, in an effort to replicate the study, CBO found no evidence that restrictions on tort liability reduced medical spending.

⁶³ K.E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs* 23 (2004): w26-w27; published online January 21, 2004.

⁶⁴ The Congressional Budget Office, "The Effects of Tort Reform: Evidence from the States," (June 2004), <http://www.cbo.gov/ftpdocs/55xx/doc5549/Report.pdf> (accessed March 31, 2009).

⁶⁵ D. P. Kessler and M. B. McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no.2 (May 1996), pp. 353-390; and Kessler and McClellan, "Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care," *Journal of Public Economics*, 84, no.2 (2002): 175-197.

We suggest that a 0.5 percent reduction in premiums with a 1 percent reduction in defensive medicine may be a sound estimate.

In 2008, New York State imposed a one-year freeze in medical malpractice premiums in New York State while legislators and stakeholders consider malpractice reform. A “no fault” system is among the reforms proposed in New York. However, according to Bovbjerg and Berenson, a “no fault” system may not reduce premiums compared to today’s system.⁶⁶ They suggest that a “no fault” system could actually increase premiums because many more claims would be brought at a much lower cost. On the other hand, a “no fault” system should reduce medical spending on extra tests and procedures by at least as much as conventional tort reform, possibly more, because defensive measures would not change the compensability of an injury. Moreover, there would be somewhat less stigma for physicians in having had a claim, which may decrease the incentives to perform defensive measures. Thus, Bovbjerg and Berenson suggest that conventional tort reforms may decrease spending by about 1 percent through a reduction in defensive measures, while a “no fault” system could decrease spending by about 1.5 percent.

Evidence on Cost Savings from Eliminating Elementary Benefit Mandates

While evidence is mixed, a review of the literature suggests that, overall, benefit mandates likely add no more than 2 to 3 percent to the costs of health insurance.

Assessing the research regarding the cost of benefit mandates is difficult since many studies are methodologically flawed.

⁶⁶ R. Bovbjerg and R. A. Berenson, “Summarization, Myths, and Mindsets in Medical Malpractice,” The Urban Institute, (October 2005).

Monheit and Rizzo conducted an extensive review of the literature on studies that have examined the impact of health benefit mandates on costs.⁶⁷ While the results are mixed, the authors ultimately conclude that there is little evidence that health insurance mandates have the large impact on health insurance premiums that critics assert. Many studies overestimate the cost of benefit mandates because they do not account for benefits that would have been offered in the absence of the mandate or for benefits that cover services that are close substitutes for mandated services. In addition, the authors argue that many studies estimate the impact of the presence of a specific benefit, rather than the addition to premium due to a mandated benefit that exceeds the benefits already in place. Overall, Monheit and Rizzo find that “there is not consistent and compelling evidence that mandates have had a major impact on health insurance premiums, coverage, and employer decisions to offer health insurance.”

In a 2000 report, the CBO also reviewed the cost of benefit mandates.⁶⁸ They concluded that estimates of the contribution of mandates to costs systematically overstated the impacts of the effective marginal costs of mandated benefits, primarily because insurance plans would often cover the service in the absence of a mandate. Overall, CBO estimated that several typical mandates taken together could increase premiums on the order of 5 percent; a subsequent GAO study in 2003 concurs largely

⁶⁷ A.C. Monheit and J. Rizzo, “Mandated Health Insurance Benefits: A Critical Review of the Literature,” State of New Jersey Department of Human Services and Rutgers Center for State Health Policy, (January 2007), <http://www.cshp.rutgers.edu/Downloads/7130.pdf> (accessed 31 March 2009).

⁶⁸ The Congressional Budget Office, “Increasing Small-Firm Health Insurance Coverage through Association Health Plans and HealthMarts,” (January 2000), <http://www.cbo.gov/ftpdocs/18xx/doc1815/healthins.pdf> (accessed 31 March 2009).

with this finding.⁶⁹ Drawing on the evidence as a whole, we estimate that the impact of benefit mandates on premiums is on the order of 2 to 3 percent.

Evidence on Cost Savings from Certificate-of-Need Policies

The literature from the 1980s and 1990s on certificate-of-need (CON) regulation, when it was much more prominent as a health care cost containment device, generally showed no impact on cost.⁷⁰ In part, studies found that dominant hospitals had considerable control over regulators' decisions and that the use of CON regulation led to increased market concentration and more pricing power among those who are protected from increased competition. Overall, there is little reason to believe that certificate of need can be effective in producing cost savings. However, CON regulation can provide levers to limit capacity, which, together with more aggressive purchasing of provider services or rate-setting, could result in lower costs. Yet, savings are likely to be no more than roughly 0.5 percent of total spending.⁷¹ The reform proposal from Assembly Member Gottfried, simulated in this report, would reintroduce health system agencies and increase the efforts to use CON regulation to eliminate redundant services.

⁶⁹ The United States Government Accountability Office, "Private Health Insurance: Federal and State Requirements Affecting Coverage Offered by Small Businesses," (September 2003), <http://www.gao.gov/new.items/d031133.pdf> (accessed 31 March 2009).

⁷⁰ Antel, John J., Ohsfeldt, Robert L., Becker, Edmund R. August 1995. State Regulation and Hospital Costs. *The Review of Economics and Statistics*. 77(3): 416-422; Mayo, John. W., McFarland, Deborah A. January 1989. Regulation, Market Structure, and Hospital Costs. *Southern Economic Journal*. 55(3): 559-69.; Rivers, *et al.* 2007. Does Certificate of Need Really Contain Hospital Costs in the United States? *Health Education Journal*. 66: 229-244.; D. Salkever, D. Steinwachs, A. Rupp, "Hospital Cost and Efficiency Under Per Service and Per Case Payment in Maryland, A Tale of the Carrot and the Stick," *Inquiry*, 1, (1986): 56-66.; Sloan, Frank A., Steinwald, Bruce. April 1980. Effects of Regulation on Hospital Costs and Input Use. *Journal of Law and Economics*. 23(1): 81-109. Sloan, Frank A. November 1981. Regulation and the Rising Cost of Hospital Care. *The Review of Economics and Statistics*. 63(4): 479-487.

⁷¹ If the kinds of services that would be shifted outside of hospitals amount to 10 percent of hospital spending and the costs of these services would increase by 10 percent, then an effective CON policy would reduce hospital spending by 1 percent and overall spending be about 0.5.

The recent development of specialty hospitals and imaging centers outside of hospital settings is a more recent focus of attention by advocates of CON regulation. The movement of these services outside of hospitals has the potential to increase competition and lower costs. CON regulation in these cases would inhibit this competition, and potentially increase overall health care costs. On the other hand, the movement of services outside of hospitals may increase costs for certain patient groups, since the ability of hospitals to cross subsidize and pay for unprofitable services with profitable ones would be reduced. The prices for these unprofitable services in hospitals—services that have high fixed costs but limited demand, e.g., burn units, trauma centers, uncompensated care—would have to increase considerably. In fact, some argue that specialty hospitals and imaging centers can increase overall health care costs, if they add to the volume of unnecessary services, which is a particular concern since physicians often have a financial interest in these facilities. Berenson *et al.* reports that insurers believe costs would be lower if there were CON regulations over the development of specialty hospitals.⁷² Overall costs could increase even further if a hospital’s market power allows it to offset their losses with higher charges. Thus, CON regulation may have some potential to reduce costs, depending on the extent to which specialty hospitals are used in the state.

⁷² Robert A. Berenson, Gloria J. Bazzoli, Melanie Aw, “Do Specialty Hospitals Promote Price Competition” Center for Health System Change, Issue Brief No. 103, January 2006.

Appendix 3. Delivery System Capacity Constraints and Modeling Methodology

In this appendix, we describe the methodology used to calculate how much of the anticipated increases in health spending under alternative health reform proposals could be met given existing capacity in New York State. The analysis of excess capacity in the current system and the development of an analytic structure for calculating potential supply constraints under reform were done by Sherry Glied of Columbia University.

Overview

While the health care delivery system has many components, we concentrate our analysis on estimation of capacity constraints related to primary care physicians (PCPs) and hospitals. There are several reasons for this focus. First, PCPs and hospitals account for a large share of health care spending. Second, although there are many other types of health care providers and health facilities (e.g., nurses, outpatient clinics), PCPs and hospitals are particularly important in influencing patient demand—the amount and type of health services used. Third, PCP visits and hospital care are a relatively inflexible part of the delivery system in the short run, and in some cases they are *already* prone to capacity constraints in some regions of the state, whereas much of the remainder of health spending (e.g., spending on prescription drugs) does not encounter supply constraints, and likely would not encounter constraints even under the most extensive reforms.

Our general approach in estimating health care delivery system capacity constraints is that projected increases in health spending as a consequence of reform will not be realized in areas where shortages of physicians already exist or where hospital

occupancy is already quite high. In addition, since physician and hospital supply varies widely across the state, we produce estimates of supply constraints that reflect this variation. Our estimates combine calculations for six regions of New York State: the Western region, Central region, Northern region, Hudson Valley region, New York City region, and Long Island region.⁷³ Estimates of PCP and hospital supply constraints are calculated separately for each region and aggregated into one estimate.

To impose our estimated supply constraints on the results of a particular reform proposal, we calculate the amount of anticipated new spending that will *not* be realized given existing capacity constraints. We use national, state, and regional New York data to estimate existing PCP and hospital capacity by region of New York State. To estimate the anticipated increases in PCP visits and hospital days under reform, we use updated results from the RAND Health Insurance Experiment (HIE) along with population and provider data from each region of the state. From these, we calculate the increases in health care utilization in response to expansions of coverage and to changes in the cost-sharing characteristics of coverage between the baseline and reform.

Detailed Description of Methods

We begin by describing how we calculate the percentage of the increased need for PCP visits that could be met by existing capacity under a reform option that would result in coverage for all. We then describe the equivalent calculation for hospital days and conclude by describing how these measures are combined into one measure for the state. The calculations focus on the non-publicly insured population—those with private coverage and the uninsured prior to reform—since the reforms in this report involve changes in coverage or in the content of coverage for them.

⁷³ For region definitions, see <http://www.nyhealthcarecommission.org/regions/>.

PCP visits. The percentage of anticipated increases in health spending when all have coverage that could be met given existing PCP capacity is calculated as follows. For each region of New York State, we first take the population with non-public coverage and use regional data to calculate the number of privately insured and uninsured. We calculate “available PCP visits” by multiplying the following: the number of primary care physicians in the region, the share of PCP revenue from individuals with non-public coverage, the average annual visits per PCP, and an estimate of the “slack” capacity necessary for a smoothly functioning health care delivery system.⁷⁴ For our estimate of necessary slack, we assume that the maximum long-term PCP capacity is equal to a capacity utilization rate of approximately 95 percent. We calculate “current PCP visits” using population estimates of privately-insured and uninsured in each New York region, combined with results from the RAND Health Insurance Experiment (HIE), which we update and calibrate, to estimate the annual number of face-to-face PCP visits given either private coverage or uninsurance.⁷⁵ We divide “current PCP visits” by “available

⁷⁴ We use data from the American Medical Association on physician visits per year and data from the Center for Health Workforce Studies on PCP-to-population ratios. (Physician Socioeconomic Statistics. 1999-2000 edition, American Medical Association, 1999. MGMA Physician Compensation Survey, 2004.) In addition, we use the assumption that 32 percent of physician use is by publicly insured people, based on MEPS-HC and CMS data.

⁷⁵ Throughout this analysis of capacity constraints, we use results from the RAND Health Insurance Experiment (HIE) estimates to describe the relationship between cost-sharing in health insurance plans and health care utilization. The HIE shows a reduction in face-to-face outpatient visits and inpatient hospital admissions associated with increasing cost-sharing (from no co-insurance, to 25 percent co-insurance, to 95 percent coinsurance). We calibrate the utilization levels in the HIE associated with particular cost-sharing to match current data on utilization of services from the MEPS-HC. We adjust the estimate of face-to-face outpatient visits to include primary care physician (PCP) visits only. We use the assumption that 2/3 of the face-to-face visits are PCP, based on Joyce GF, Kapur K, Van Vorst KA, Escarce JJ. “Visits to primary care physicians and to specialists under gatekeeper and point-of-service arrangements,” *Am J Manag Care*. 2000 Nov;6(11):1253-4. We use these recalibrated RAND HIE figures to estimate current service use and to estimate increases in service use due to expanding coverage or to increasing the comprehensiveness of coverage under different reform scenarios.

PCP visits” to produce current PCP capacity utilization rates. Estimates range from 69.1 percent in New York City to 99.6 percent in the Western region.⁷⁶

We then turn to calculating anticipated increases in PCP visits. We estimate “future PCP visits” based on our population counts and calibrated results from the RAND HIE, showing the percent change in face-to-face PCP visits given that both privately insured and uninsured move to first-dollar health insurance coverage. By subtracting “current PCP visits” from “future PCP visits,” we get the anticipated increase in PCP visits. By subtracting “current PCP visits” from “available PCP visits,” we get the estimated number of visits that are available but unused. By dividing these quantities we can then calculate the percentage of increased need for PCP visits that is met. Estimates vary by region, with a population-weighted average of 39 percent of increased PCP need met when both insured and uninsured move to first-dollar health insurance coverage.

Hospital use. The percentage of anticipated increases in health spending when all have coverage that could be met given existing hospital capacity is calculated as follows. We calculate “available hospital days” using data on hospital capacity, occupancy, uninsured rates, length of stay and non-publicly insured population for the six regions of New York State.⁷⁷ We incorporate an estimate of the “slack” capacity necessary for a smoothly functioning health care delivery system. Estimates from Green and Nguyen (2001) suggest a maximum long-term hospital occupancy rate of approximately 85

⁷⁶ We recalibrate estimates for PCP capacity so that current capacity utilization is no higher than 95%; this requires small recalibrations in the rural areas of New York State, no larger than 0.95. In addition, our estimates are slightly lower if we do not adjust to allow for slack capacity.

⁷⁷ Available hospital capacity is recalibrated for each region of New York State so that estimated hospital occupancy matches the New York Healthcare Commission estimates. For most regions, recalibration factors are quite low (.7-1.7), but for the Central region, the hospital recalibration factor is 2.4.

percent.⁷⁸ We calculate “current hospital days” using population estimates of privately-insured and uninsured in each New York region, combined with results from the RAND Health Insurance Experiment (HIE), which we update and calibrate, to estimate the annual number of hospital days given either private coverage or uninsurance. We divide “current hospital days” by “available hospital days” to get current hospital capacity utilization. Estimates for current hospital capacity utilization range from 64.9 percent in the Western region to 84.7 percent in the Long Island region. These estimates are significantly lower if we do not adjust to allow for slack capacity; without the adjustment for slack, estimates of utilization match fairly closely to estimates from the New York Healthcare Commission survey.

We then turn to calculating anticipated increases in hospital days under reform proposals. We estimate future increases in hospital days based on our calibrated results from the results from the RAND HIE, assuming that both insured and uninsured move to first-dollar health insurance coverage, as in the PCP calculations above.⁷⁹ By subtracting “current hospital days” from “future hospital days,” we get the anticipated increase in days. By subtracting “current hospital days” from “available hospital days,” we get the estimated number of days available but unused. By dividing these quantities we can then calculate the percentage of increased need for hospital days under reform that is met. Estimates vary by region, with a population-weighted average of 72 percent of increased hospital need met when both insured and uninsured move to first-dollar health insurance coverage.

⁷⁸ L V Green and V Nguyen, “Strategies for cutting hospital beds: the impact on patient service.” *Health Serv Res.* 2001 June; 36(2): 421–442.

⁷⁹ In addition, we use the assumption that 52 percent of hospital use is by publicly insured people, based on MEPS-HC and CMS data.

The combined measure. From the calculations above, we have combined regional estimates of the percentage of increased need met for our separate calculation for PCPs and hospitals. We then combine the estimates for PCP and hospital by weighting each by the share of total expenditures accounted for by PCP and hospital care. The remaining expenditures (approximately 40 percent of the total) are for other services (e.g., prescription drugs) which we assume to be unconstrained. In all, we find that about 83 of the large estimated increase in expenditures from moving all New Yorkers to free care could be met given existing hospital and PCP capacity.⁸⁰ These estimates contain a further assumption that there will not be shortages of specialist capacity; estimates of “need met” would be lower if we assume that specialist capacity will be constrained when PCP capacity is constrained.⁸¹

Longer term constraints. The extent to which supply constraints endure beyond a transition period, i.e., beyond the tenth year after reform, depends on a number of factors affecting physician supply and inpatient capacity. Physician supply is likely to change slowly in response to changes in payment rates, although some substitution to ancillary providers (e.g., nurse practitioners and physician assistants) might occur. Presumably, inpatient capacity could be more easily adjusted by increasing the share of existing hospital physical plant space for acute care services.

⁸⁰ We calculated capacity constraints under an alternative assumption that both insured and uninsured move to private coverage with standard cost-sharing. In this case, we find that nearly all of the increase in demand can be met. About 98 of the anticipated increase in expenditures from moving all uninsured New Yorkers to private coverage could be met given existing hospital and PCP capacity.

⁸¹ Adding shortages of specialist capacity reduces the percent of the anticipated increase in “need met” to approximately 73 percent.

Appendix 4. Full Modeling Results

Overview

The results for the simulations of each reform option are provided below in detail.

We provide reform effects in sets of 4 tables:

- health insurance coverage effects are in Tables 1A-1D;
- health care spending effects for government, employers, and individuals are in Tables 2A-2D;⁸²
- effects of reforms on the share of workers who are offered health insurance by their employers are shown in Tables 3A-3D; and
- effects of reforms on employer-sponsored and private non-group insurance premiums are found in Tables 4A-4D.

The “A” tables show results for Models 1-1 through 1-5, the “B” tables show results for Models 1-6 through 1-10, the “C” tables show results for Models 1-11 through 1-15, and the “D” tables show results for Models 1-16 through 4-1, with the models numbered according to their descriptions in Section 3. In this section, we highlight the main findings from the results presented in the tables.

It is important to keep in mind that these results do not include full financing of the health care reforms simulated or the full distributional consequences (i.e., who would bear the costs of whichever financing approach is taken). The only portion of financing presented here is the revenue raised through assessments on employers that were important design components of Models 1-6, 1-12 to 1-18, and 3-1. There are a variety of approaches that could be used to finance the costs of all of the models presented here. Exploring these options is beyond the scope of this report.

⁸² The cost tables do not report uncompensated care costs or how they change under the different policy options.

Coverage effects. The two public coverage-centered options, Public Health Insurance for All (Model 2-1) and the New York Health Plus plan (Model 3-1), would both achieve coverage for all in the state. The Public Health Insurance for All approach would automatically enroll all permanent residents into the new program. The New York Health Plus approach would effectively do the same, as all individuals who did not voluntarily enroll in some type of coverage would be automatically enrolled in the new public insurance plan. The public-private hybrid approaches that include an individual mandate (a legal requirement that all individuals enroll in insurance coverage of a minimum level) – Models 1-11, 1-16, 1-17, and 1-18 – would also achieve coverage for all, assuming aggressive auto-enrollment strategies and significant financial penalties for non-compliance. Those models that include neither public program options covering all residents nor an individual mandate will leave a portion of the population uninsured post-reform. Of the reforms that would *not* achieve coverage for all, Model 1-10 would increase coverage the most, and Model 1-1 would have the smallest effect on insurance coverage.

Cost effects. Some redistribution of health care spending is inherent in all health care reforms. The Public Health Insurance for All and the New York Health Plus plan approaches will increase government spending while generating savings to individuals and employers. Public-private hybrid approaches will tend to increase government spending, but less so than the public-centered options, with government spending increasing with the level of premium subsidies. The greater the investment in insurance coverage by the government, the greater the savings for individuals and employers. To the extent that reforms, such as the modified “Freedom Plan” approach, encourage the

purchase of less comprehensive insurance policies, private premium savings will be achieved, but at the cost of higher out-of-pocket costs to those with the greatest health care needs. Likewise in the modified “Freedom Plan” approach that would allow variation in non-group premium prices by policy form, costs will be shifted towards those who are the highest users of medical care while savings will be realized by the healthiest.⁸³

New government costs will be divided between the federal government and the state government. The share of new spending paid by the federal government is uncertain, since it will depend on negotiations between the federal government and the state (e.g., Medicaid waiver). As a consequence of this uncertainty, we do not attempt to divide government costs, and we present them here as total federal and state spending.

Those approaches that achieve coverage for all will tend to increase overall health care spending in the system (including public and private spending) the most, while those with modest impacts on insurance coverage will have smaller effects on system-wide spending.

Employer-sponsored insurance offer effects. Options that provide large expansions of public programs will decrease the likelihood of ESI offers the most. Proposals that would make public coverage available to all would generally result in large reductions in ESI offers. Those options that make private non-group insurance more attractive than it is today, for example by providing extensive subsidies for its purchase, will have the effect of lowering employer-sponsored insurance offers as well, but to a substantially lesser extent. Employer mandates would provide additional

⁸³ We believe that rating by policy form would open the door to significant segmentation of health care risk, substantially undermining the risk pooling inherent in community rating, and we have modeled it as such.

incentives for employers to offer coverage. Individual mandates, by boosting demand for ESI among workers, would also lead to more employer offers.

Premium effects. Premiums in private insurance markets are determined largely by the expected costs of the groups of individuals that enroll in that coverage. Reforms will tend to make certain types of coverage (e.g., ESI, private non-group insurance, Medicaid/CHIP) more attractive than they are today, while making other types of coverage or remaining uninsured less attractive. Some reforms, such as the modified “Freedom Plan” approach modeled here, will change the rules by which insurers are allowed to set premiums, thereby making certain types of coverage more or less attractive to particular groups of individuals. As individuals and groups change their health insurance coverage decisions, the average health care costs of those in a particular type of coverage are likely to change as well, leading to changes in private health insurance premiums post-reform.

Increasing access to comprehensive low or no cost public insurance coverage under reform will tend to disproportionately pull individuals with high medical needs out of private insurance pools and into public plans because they would benefit the most from lower cost sharing. This dynamic will tend to lower premiums in the private insurance market. Merging the small group market with the non-group market will decrease premiums in the non-group market substantially, as the high costs associated with current non-group enrollees are spread more broadly. As non-group market premiums fall, lower cost individuals will be attracted into that market.

What follows are the detailed results that show the State's baseline prior to reform and the State impacts of each of the 21 reform options simulated. Note, those with Medicare coverage are excluded from all of the statistics presented.

New York State at Baseline. See summary Tables 1A-4A, column 0.

- Currently in New York State, 10.5 million people (61.1 percent of the population) have health insurance coverage through employer-sponsored insurance (ESI). Medicaid/CHIP (which includes Family Health Plus and Children's Health Plus) covers 3.7 million people, or 21.4 percent. About 250,000 or 1.4 percent are covered through the non-group market (including standard and non-standard non-group coverage and coverage through the Healthy New York program). An estimated 2.7 million people in the state are uninsured (15.8 percent).^{84 85 86} [Table 1A, column 0]
- Government spending for Medicaid/CHIP in New York State is approximately \$28.5 billion in acute care coverage for the non-elderly.⁸⁷ [Table 2A, line a] Employers in New York State spend approximately \$33.3 billion on employer-sponsored insurance for employees and their dependents. [Table 2A, line i] Individuals spend approximately \$22.0 billion, including health insurance premiums, coinsurance, and deductibles for those with coverage through ESI and the non-group market and including out-of-pocket spending for those who are uninsured as well as insured. [Table 2A, line o]
- Among small firms (fewer than 50 employees at all locations) in New York State, 63.1 percent of employees have an offer of ESI; among large firms (50 or more employees at all locations), 92.0 percent of employees have an offer of ESI. [Table 3A, column 0]
- Average premiums in the small group employer-sponsored insurance market average \$5,994 for single coverage and \$15,253 for family coverage. Average premiums in the large group market are \$5,240 and \$13,408 for single and family coverage, respectively. [Table 4A, column 0]
- Average premiums in the standardized private non-group market are \$11,644 for single coverage and \$26,183 for family coverage.

⁸⁴ The Current Population Survey for 2007, which was used for our population targets, showed 2.66 million uninsured in NY for 2006. Adjusted for expected population growth, we obtain 2.71 million uninsured in NY in 2009. Subsequent to creating our baseline file, the 2008 CPS was released which shows 2.46 million uninsured in 2007.

⁸⁵ The baseline data include undocumented immigrants, although they are thought to be somewhat underrepresented in the CPS.

⁸⁶ There are an estimated 178,000 sole proprietors among the uninsured.

⁸⁷ The \$28.5 billion includes CHIP spending and reflects growth to 2009. It excludes Medicaid spending on the aged and long term care. Average spending per person under Medicaid/CHIP is \$7,703. This is higher than typical single ESI premiums because the Medicaid/CHIP program covers many disabled people and a disproportionate number of individuals with high medical costs.

Public/Private Hybrid Approaches.

Simulation of Model 1-1: Public program expansions for all adults in families with incomes up to 160 percent of the FPL (see Tables 1A-4A):

- Medicaid/CHIP coverage increases by about 520,000 people; however, ESI falls by almost 175,000; there is virtually no change in non-group coverage, leaving a net coverage increase of slightly more than 350,000.
- Under this public program expansion, the share of the population uninsured declines by 13.4 percent. Some individuals are eligible for public insurance post-reform, but have not enrolled. Those individuals could be enrolled at very low or no cost in a public program. Taking those individuals into account, 92.9 percent of New York's residents would either have private or public coverage or be eligible for a public program (Medicaid/CHIP) post-reform.
- Total government spending increases by \$1.5 billion. Employer spending decreases by \$570 million; and individual spending decreases by \$240 million. However, low-income individuals and families see savings of \$576 million, and higher income families see modest spending increases in aggregate, on the order of about 2 percent of their baseline spending.
- Government cost per newly insured is \$4,117.
- The share of employees offered ESI decreases by 3.3 percentage points among small firms and by 0.7 percentage points among large firms. The reduction in ESI offers leads some workers to lose ESI coverage and is the reason that spending increases somewhat among higher income individuals and families.
- There is virtually no change in employer premiums as a consequence of the public program expansion. There are some small declines in private non-group premiums as some workers who lose ESI coverage but do not qualify for public coverage purchase non-group coverage.
- Aggregate health system spending increases by \$685 million.

Simulation of Model 1-2: Public program expansions for all adults in families with incomes up to 200 percent of the FPL; summary Tables 1A-4A:

- Medicaid/CHIP coverage increases slightly more than in the previous simulation, by about 775,000 people. ESI falls by a little more, about 260,000, non-group coverage remains stable, leaving a net coverage increase of about half a million.
- Under this public program expansion, the share uninsured declines by 19.6 percent. Some individuals are eligible for public insurance post-reform, but have not enrolled. Those individuals could be enrolled at very low or no cost in a public program. Taking those individuals into account, 94.1 percent of New York's residents would either have coverage or be eligible for a public program (Medicaid/CHIP) post-reform.
- Total government spending increases by \$2.3 billion. Employer spending decreases by \$0.9 billion; individual spending decreases by \$0.5 billion. As in Model 1-1, savings accrue to the low-income population (here, \$1.0 billion in aggregate savings), while the higher income groups' spending increases modestly.
- Government cost per newly insured is somewhat higher than in the previous simulation, at \$4,392. This is because the higher the income eligibility cut-off for

- Medicaid/CHIP eligibility, the greater the likelihood that some who take advantage of the expansion have previously had private insurance coverage.
- The share of employees offered ESI decreases by 4.3 percentage points among small firms and by 0.7 percentage points among large firms.
 - Again, the effect of the reform on private insurance premiums is small.
 - Aggregate health system spending increases by \$931 million.

Simulation of Model 1-3: Public program expansions for all adults in families with incomes up to 200 percent of the FPL (Model 1-2) plus merge of the non-group market and small group market for firms up to 50 employees; summary Tables 1A-4A:

- Medicaid/CHIP coverage increases by slightly more than under the public expansion alone (850,000 people). ESI falls by somewhat more than the previous simulation, 440,000. Non-group increases by 200,000 as individuals gain access to a larger more diverse pool in which to purchase coverage. This produces a net coverage increase of 600,000.
- Under this voluntary system of reforms, the share uninsured declines by 22.4 percent. 94.2 percent of the state population is either eligible for public coverage (Medicaid/CHIP) or insured post-reform.
- Government spending increases by virtually the same amount as under the public expansion alone (\$2.5 billion); employer spending decreases by \$1.5 billion, as additional firms stop offering insurance coverage; individual spending decreases by \$0.3 billion, with the savings again accruing to the low-income population.
- Government cost per newly insured is \$4,089. The voluntary increase in unsubsidized coverage in the private non-group insurance market brings down the government cost per newly insured relative to the public expansion alone.
- The share of employees offered ESI decreases by 6.7 percentage points among small firms and 1.3 percentage points among large firms.
- While a merge of the small group and non-group markets alone would increase small group premiums but create much larger declines in non-group premiums, the changes are not as straight-forward when combined with a public program expansion as is the case here. In this situation, the Medicaid program expansion attracts some of the high cost low income population out of private insurance coverage at the same time as the small group and non-group pools are joined, bringing down the average cost of single policyholders in the private market. As the premiums in the private merged market decline as a result of the exit to Medicaid and the broader pooling, more healthy previously uninsured single people enter private coverage. As a consequence, small group single premiums actually decline somewhat as a result of the reforms. There is little change on net to family premiums since the entrance into private coverage and the exit from private coverage into Medicaid is dominated by singles, not families (because of the large number of singles below 200 percent FPL who become newly eligible). Very large premium savings are achieved in the non-group market – 56 percent on single policies and 43 percent on family policies.

NOTE: Average small group premiums are not exactly equal to non-group premiums after the markets are merged because a small share of small group

employers are self-insured, and their premiums are reflected in the small group averages in the tables.

- Aggregate health system spending increases by \$644 million.

Simulation of Model 1-4: Public program expansions for all adults in families with incomes up to 200 percent of the FPL (Model 1-2) plus merge of the non-group market and small group market for firms up to 100 employees; summary Tables 1A-4A:

- The results when merging the non-group market with those in the small group market up to 100 employees are very similar to that when the merge only includes small groups up to 50 employees. Consequently, we do not describe the results in detail. It is notable that including the 50 to 100 worker firms in the merge does not substantially impact the average cost of those in the market compared to the previous simulation.

Simulation of Model 1-5: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus government funded reinsurance to compensate small employer purchasers for any adverse premium impact resulting from the merging of the small group and non-group markets; summary tables 1A-4A:

- Likewise, the health insurance coverage effects of this model are not noticeably different than those in Model 1-3.
- Government costs are modestly higher than under Model 1-3, taking into account the extra \$143 million in government funded reinsurance to the merged small group and non-group markets.⁸⁸ While single premiums in the small group market fell due to the merge (see Model 1-3 results), family premiums rose modestly. The reinsurance amount is the amount necessary to ensure that those purchasing family coverage would not face premium increases. Because the markets were merged, the reinsurance had to be applied both to the small group and non-group markets. Employer spending fell by \$1.4 billion and aggregate individual spending by \$300 million.
- Government cost per newly insured person is \$4,192.
- Offer rates fell by slightly less than in Model 1-3: 6.6 percentage points for small firm workers and 1.7 percentage points for large firm workers, as the government reinsurance makes the non-group market slightly more attractive.
- Premiums for private insurance were modestly lower compared to Model 1-3 for both small employers and non-group purchasers, reflecting the effect of the government reinsurance.
- Aggregate health care system spending increased by \$834 million.

⁸⁸ Applying the model iteratively, we determined the amount of subsidy delivered through a reinsurance program (applied to individual claims) that would be required to leave both individual and family small group premiums no higher than they were before the market merge. Healthy New York was not incorporated into the merge.

Simulation of Model 1-6: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus a payroll assessment on employers of 50 or more employees. The payroll assessment liability can be offset dollar for dollar by the amount an employer contributes to its employee's health insurance. The size of the payroll assessment varies with each employee's wages, such that lower assessments are imposed on low-wage employees, higher assessments imposed on higher-wage employees; summary Tables 1B-4B:

- Coverage results in this model are similar to those in Model 1-3, but there is slightly more employer coverage under Model 1-6 because the employer assessment on large firms serves to reduce the negative effect that the reforms have on employer insurance offers.
- 23.4 percent of the uninsured gain coverage under this reform, compared to 22.4 percent under Model 1-3. 94.4 percent of the population would either have coverage or be eligible for public coverage (Medicaid/CHIP) post-reform.
- With slightly more employer based coverage in Model 1-6 than in Model 1-3, employer spending on premiums is modestly higher. In addition, employers that do not offer insurance coverage pay \$496 million in payroll assessments to the state. These assessments are then used to offset the cost of the public program expansion.
- The gross government cost per newly insured is \$3,878, and *net* government cost per newly insured – after taking into account estimated payroll assessment revenue – is \$3,094. The payroll assessment is just one of several mechanisms that can be used to fund coverage expansions; the increases in government costs would need to be financed in each of the models simulated.
- The assessment on large firms increases employer sponsored insurance offers relative to Model 1-3. In Model 1-6, the share of workers in small firm with employer offers of health insurance drops by 7.1 percentage points and by 0.3 percentage points for workers in large firms.
- There is very little difference in private premiums between Models 1-6 and 1-3.
- Aggregate health care spending increases by \$647 million under this approach.

Purchasing pool coverage for individual non-group purchasers and small employers is included as a component of each of the following models, Model 1-7 through Model 1-18. Post-reform results for those obtaining coverage through the new purchasing pool are included in the ESI or non-group coverage totals depending on how they enroll in the pool.

Simulation of Model 1-7: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus purchasing pool, and Subsidy Schedule A for those up to 300 percent of the FPL; summary Tables 1B-4B:

- Over and above the Medicaid expansion included in Model 1-3, this model provides subsidies for the purchase of private insurance coverage to those between 200 and 300 percent of the FPL. As a consequence, enrollment in non-group coverage increases by 440,000 people, more than twice the increase seen in Model 1-3. Medicaid/CHIP coverage increases by over 900,000 people; however, ESI falls by almost 600,000. On net, insurance coverage increase by 770,000 people.
- Under this voluntary system of reforms, the share uninsured declines by 28.4 percent. 95 percent of State residents are either insured or eligible for public insurance program (Medicaid/CHIP) coverage post-reform.
- Total government spending increases by \$4.4 billion. Employer spending decreases by \$2.0 billion. Individual spending decreases by \$642 million in aggregate, with significant savings (\$1.1 billion) accruing to the low income population with modest spending increases occurring among the higher income groups.
- Government cost per newly insured is \$5,664.
- The share of employees offered ESI decreases by 6.2 percentage points among small firms and 1.6 percentage points among large firms.⁸⁹
- Premiums for small employer coverage and private non-group coverage decrease further for both singles and families under this reform, as lower cost uninsured people enroll in private subsidized coverage.
- Aggregate health system spending increases by \$1.7 billion.

Simulation of Model 1-8: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus purchasing pool, and Subsidy Schedule A for those up to 400 percent of the FPL; summary Tables 1B-4B:

- This model extends subsidies beyond those offered under Model 1-7, to those up to 400 percent of the FPL. As a consequence, 825,000 people gain coverage. Medicaid/CHIP coverage increases by 924,000 people; however, ESI falls by 600,000 and non-group increases by 500,000. This leaves a net coverage increase higher than in the previous simulation, due to the expansions in subsidy eligibility to some higher income individuals.
- Under this voluntary system of reforms, the share uninsured declines by 30.4 percent. 95.3 percent of the population would either have coverage or be eligible for public program coverage (Medicaid/CHIP) post-reform.
- Total government spending increases by \$4.6 billion, slightly more than in the previous simulation. Employer spending decreases by \$2.3 billion; individual

⁸⁹ Compared to Model 1-3, Model 1-7 shows a larger drop in ESI and a larger increase in non-group coverage. At the same time, it shows a smaller drop in offer of small firms but a slightly higher drop in offer in large firms. This pattern arises because Model 1-7 attracts people in large firms from ESI to non-group coverage, even as more small employers offer due to the new subsidies. In addition, employer costs fall by more in Model 1-7 compared to Model 1-3 because there is less overall ESI coverage in Model 1-7.

- spending decreases by \$616 million.⁹⁰ Again, sizable savings accrue to the low income, with modest spending increases for the higher income.⁹¹
- Government cost per newly insured is \$5,612.
 - The share of employees offered ESI decreases by 5.8 percentage points among small firms, a slightly smaller drop than under Model 1-7.⁹² Some additional lower cost uninsured families join the subsidized private insurance pool, thereby lowering the family premiums for small employers and non-group purchasers somewhat further. There is a 1.6 percentage point decline in the share of employees offered ESI in large firms.
 - Premiums for small employers fall post-reform and those for large employers increase modestly. Large declines in non-group coverage premiums occur for both singles and families.
 - Aggregate health system spending increases by \$1.7 billion.

Simulation of Model 1-9: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus purchasing pool, and subsidy schedule B for those up to 400 percent of the FPL; summary Tables 1B-4B:

- Model 1-9 offers more extensive subsidies for the purchase of private coverage to the same populations as Model 1-8. Medicaid/CHIP coverage increases by about 1 million people; however, ESI falls by almost 900,000 and non-group increases by 800,000. With significantly higher subsidies available through the non-group market, there is a decrease in employer-sponsored insurance relative to Model 1-8 among large firm workers. The higher subsidies do not lead to as large of a net coverage increase as one might expect when compared to Model 1-8, since the lower subsidies already led to high participation rates among the previously uninsured who were eligible for them. The number of uninsured declines by over 900,000 under this model.
- Under this voluntary system of reforms, the share uninsured declines by 33.8 percent. 95.8 percent of the population would either have insurance coverage or be eligible for coverage through a public program (Medicaid/CHIP) post-reform.
- Total government spending increases by \$7.4 billion. The higher government costs compared to the previous simulation are primarily due to the fact that those who purchase coverage through the new purchasing pool are eligible for far larger subsidies under this schedule. Employer spending decreases by \$3.0 billion; individual spending decreases by \$1.9 billion, with significant savings accruing to both those under 200 percent of the FPL and those between 200 and 399 percent of the FPL.

⁹⁰ Individual spending is reduced slightly less than in Model 1-7 even though the subsidy schedule in Model 1-8 is more generous because many of the uninsured who are induced to obtain coverage under the more generous subsidy have higher out-of-pocket costs once they are insured.

⁹¹ There are small variations in individual spending by the less than 200 percent FPL groups (who are not eligible for the purchasing pool subsidies) under the different subsidy schedules. These minor differences result from several sources including the types of coverage held by Medicaid/CHIP eligible individuals who are not enrolled and the premiums they face.

⁹² The more generous subsidies in Model 1-8 compared to Model 1-7 cause more workers in large firms to switch to non-group coverage, but lead more small firms to continue offering ESI coverage.

- Government cost per newly insured is \$8,066.
- The share of employees offered ESI decreases by 5 percentage points among small firms and 2.1 percentage points among large firms.
- Premiums are very similar to those in Model 1-8.
- Aggregate health system spending increases by \$2.5 billion.

Simulation of Model 1-10: Public program expansions for all adults in families with incomes up to 200 percent of the FPL and merge of the non-group market and small group market for firms up to 50 employees (Model 1-3) plus purchasing pool, and subsidy schedule B for those up to 600 percent of the FPL; summary Tables 1B-4B:

- This model extends the higher subsidies offered under Model 1-9 to individuals with incomes between 400 and 600 percent of the FPL. Doing so expands insurance coverage beyond Model 1-9 a modest amount, decreasing the number uninsured by 1 million. Medicaid/CHIP coverage increases by about 1 million, but ESI falls by even more people than under Model 1-9, as the non-group subsidized option attracts even more individuals out of large group coverage. This dynamic limits somewhat the net impact of the increased subsidies on overall insurance coverage. But more importantly, there are small numbers of uninsured between 400 and 600 percent of the FPL, which more significantly limits the ability of Model 1-10 to increase coverage beyond Model 1-9.
- Under this voluntary system of reforms, the share uninsured decline by 36.2 percent. 96.2 percent of the State population would either have insurance coverage or be eligible for a public insurance program (Medicaid/CHIP) under this approach.
- Total government spending increases by \$8.1 billion, since eligibility for the higher subsidies under Schedule B is expanded still further. Employer spending decreases by \$2.8 billion; individual spending decreases by \$1.7 billion, with significant savings accruing to those below 400 percent of the FPL, but the greatest savings going to those below 200 percent of the FPL.
- The government cost per newly insured is \$8,283, reflecting the combination of a very high subsidy schedule and eligibility for subsidies by more people with pre-reform insurance coverage.
- The share of employees offered ESI decreases by 4.7 percentage points among small firms and 2.3 percentage points among large firms.
- Average employer premiums in the large firms increase somewhat compared to the prior model, as lower cost firms leave the employer-based insurance system. Premiums in the non-group market under this reform are essentially the same as under Model 1-9.
- Aggregate health system spending increases by \$3.6 billion.

Simulation of Model 1-11: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, and Subsidy Schedule A for those up to 400 percent of the FPL (Model 1-8) plus an individual mandate on all adults and children; summary Tables 1C-4C:

- Theoretically, this reform would reduce the number of uninsured to zero. While simulating the effect of the mandate as complete may not be entirely realistic, doing so envisions an automatic insurance enrollment process for those not complying with the mandate, and allows us to estimate the private and public costs associated with coverage for all New Yorkers. Medicaid/CHIP coverage increases by 1.9 million people, and ESI stays stable. Non-group coverage increases by 860,000.
- Total government spending increases by \$7.1 billion. Employer spending decreases by \$1.6 billion. Employer savings are lower than under the voluntary reform, Model 1-8, because more employers offer coverage when an individual mandate is in place. Given the requirement that everyone have coverage, many workers will prefer to obtain that coverage through their employers. Individual spending increases modestly in aggregate, by \$316 million. Significant savings (\$1.6 billion) still accrue to the low income, but requirements to obtain coverage require some higher income individuals to contribute toward coverage when they would be uninsured without the mandate.
- Due to the increased enrollment in both Medicaid/CHIP and the purchasing pool resulting from the individual mandate – including many individuals with lower average health expenditures – government cost per newly insured drops to \$2,635 compared to \$5,612 without the individual mandate (Model 1-8).
- The share of employees offered ESI decreases modestly by 1.9 percentage points among small firms and by 0.2 percentage points among large firms.
- Premiums across the private sector plans are lower than under the voluntary reform, as lower cost individuals are brought into the insurance pools as a consequence of the mandate.
- The aggregate change in health system spending under this reform is an additional \$5.9 billion dollars.

Simulation of Models 1-12 through 1-15: Each of these models include public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, and Subsidy Schedule A for those up to 400 percent of the FPL (Model 1-8) plus an employer assessment (i.e., pay-or-play mandate) on employers. They differ by whether there is an exemption for small firms from the employer assessment, and if so how large it is. Model 1-12 has no exemptions, Model 1-13 an exemption for employers with fewer than 10 workers, Model 1-14 an exemption for employers with fewer than 25 workers, and Model 1-15 an exemption for employers with fewer than 50 workers. See summary Tables 1C-4C:

- Coverage results are highly consistent across the 4 models. Medicaid/CHIP coverage increases by 899,000 to 922,000 people, with the increase in Medicaid going up the more firms are exempt from the mandate. ESI falls by 579,000 to 667,000 people, with the decline the smallest the greater the number of employers covered by the assessment. Non-group coverage increases by 578,000 to 604,000 people, with the increase climbing slightly the more employers are exempted from the mandate.

- Under these voluntary systems of reform, the share uninsured declines by 33.1 to 31.7 percent, with coverage expansion being modestly higher for those options that include more employers in the assessment. 95.7 to 95.5 percent of the state's non-elderly population would either have insurance coverage or be eligible for public insurance (Medicaid/CHIP) under this approach.
- Gross total government spending increases by \$5.4 billion for each option (Table 2C, subtracting row b from row a). Subtracting out assessments paid by employers, leaves net total government spending increasing by \$3.9 to \$4.8 billion (row e), with net costs lowest for the options that include more employers in the assessment. Employer spending decreases by \$903 million to \$2.0 billion, with premium spending falling under each option, but assessments totaling \$517 million to \$1.5 billion, depending upon the inclusivity of the assessment. The employer mandate with no exemptions would lead to relatively larger employer spending increases among smaller employers, who are least likely to offer under the current system and are therefore those most likely to be affected by a new pay-or-play requirement. The more small firms exempted, the smaller the effect on employer spending. Individual spending decreases by \$864 million to \$1.1 billion.
- Gross government cost per newly insured is \$6,044 to \$6,250; the net government cost (subtracting out the employer assessments) per newly insured is \$4,374 to \$5,648. The higher net costs are attributable to the options with fewer employers subject to the assessment.
- The share of employees offered ESI decreases by 3.0 to 5.9 percentage points among small firms, compared to a decrease of 5.8 percentage points without the employer pay-or-play mandate (Model 1-8). The more small firms exempt, the greater the decline in ESI offer. Smaller employers are least likely to offer under the current system and are therefore most likely to be affected by the new pay-or-play mandate. The offer rates for large firm workers falls by 0.6 percentage points post-reform under each option.
- Private insurance premiums in the employer and non-group markets are just about the same as in Model 1-8.
- The aggregate change in health system spending under these reforms would range from an additional \$1.8 to \$2.0 billion dollars.

Simulation of Model 1-16: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL, and an employer assessment (i.e., pay-or-play mandate) on all employers (no exemptions) (Model 1-12) plus an individual mandate. See summary Tables 1D-4D:

- Medicaid/CHIP coverage increases by 1.9 million people, ESI falls by 150,000, and non-group increases by almost 1 million. Theoretically, this reform would reduce the number of uninsured to zero.
- Gross total government spending increases by \$8.1 billion. Subtracting out assessments paid by employers, leaves net total government spending increasing by \$6.8 billion. Employer spending decreases by \$642 million (premium

spending falls, but new assessments add \$1.4 billion). Individual spending decreases by \$212 million, with \$1.6 billion in savings accruing to the low income households and increases in spending of \$1.4 billion in aggregate by the higher income.

- Gross government cost per newly insured is \$3,005; the net government cost per newly insured is \$2,507. The cost per newly insured is much lower under an individual mandate, as more healthy individuals and those that are not eligible for subsidies or public insurance are required to obtain coverage.
- The share of employees offered ESI decreases by 0.9 percentage points among small firms and by 0.1 percentage points for employees of large firms.
- Private insurance premiums in both the group and non-group markets are lower once a mandate is put in place, as the mandate brings in previously uninsured individuals who tend to be less costly on average than the insured.
- The aggregate change in health system spending under this reform is an additional \$5.9 billion dollars.

Simulation of Model 1-17: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up to 400 percent of the FPL, and an employer assessment (i.e., pay-or-play mandate) on all employers (Model 1-12) (small firm exemption for those with fewer than 10 workers) plus an individual mandate. See summary Tables 1D-4D:

- Coverage results for this model are very similar to that for Model 1-16. Medicaid/CHIP coverage increases by 1.9 million people, ESI falls by 170,000, and non-group increases by almost 1 million. Theoretically, this reform would reduce the number of uninsured to zero.
- Gross total government spending increases by \$8.0 billion. Subtracting out assessments paid by employers, leaves net total government spending increasing by \$7.2 billion. Employer spending decreases by \$1.2 billion (premium spending falls, but new assessments add \$0.8 billion). Individual stays essentially the same overall, but with \$1.6 billion in savings accruing to the low income households and increases in spending of \$1.5 billion in aggregate by the higher income.
- Gross government cost per newly insured is \$2,959; the net government cost per newly insured is \$2,663.
- The share of employees offered ESI decreases by 1.5 percentage points among small firms and by 0.1 percentage points for employees of large firms.
- Private insurance premiums in both the group and non-group markets are lower once a mandate is put in place, as the mandate brings in previously uninsured individuals who tend to be less costly on average than the insured. The premiums in Model 1-17 are very similar to those in Model 1-16.
- The aggregate change in health system spending under this reform is an additional \$6.0 billion dollars.

Simulation of Model 1-18: Public program expansions for all adults in families with incomes up to 200 percent of the FPL, merge of the non-group market and small group market for firms up to 50 employees, purchasing pool, Subsidy Schedule A for those up

to 400 percent of the FPL, an employer assessment (i.e., pay-or-play mandate) on all employers (small firm exemption for those with fewer than 10 workers), and an individual mandate (Model 1-17) with a public insurance plan offered in the purchasing pool for small employer and individual purchasers. See summary Tables 1D-4D:

- The coverage effects under Model 1-18 are the same as those under Model 1-17, including coverage for all New York residents.
- Due to the savings realized by the presence of the public plan in the subsidized purchasing pool, government spending is slightly lower overall than under Model 1-17, with \$7.9 billion in total new government costs, which is reduced to \$7.1 billion once the employer assessments are netted out. Only 1/3 of the savings associated with the public plan option are assumed to be realized here, as this simulation represents an early year in the post-reform period. Employer and individual spending fall slightly as well compared to the previous model without the public plan option.
- Likewise, the government cost per newly insured is just slightly below those in Model 1-17, \$2,926* before assessments are netted out, and \$2,630* after.
- Offer rates are the same as in Model 1-17. The share of employees offered ESI decreases by 1.5 percentage points among small firms and by 0.1 percentage points for employees of large firms.
- Private insurance premiums within the purchasing pool fall modestly due to the presence of the public plan option. This is reflected in the small group and non-group premiums being slightly lower than in Model 1-17.
- The aggregate change in health system spending under this reform is an additional \$5.6 billion dollars.
- Larger long-run savings from the pool would increase the differences between Models 1-17 and 1-18 over subsequent years.

Public Health Insurance for All.

Simulation of Model 2-1: Public Health Insurance for All. Aside from Medicaid eligibles, all New York State residents would be enrolled in a fully publicly financed first-dollar coverage insurance plan. See summary Tables 1D-4D:

- Under this option, all those eligible for Medicaid would be automatically enrolled in that program, increasing the size of that program by 2.4 million people. All other State residents would be automatically enrolled in the new public plan and private coverage would be eliminated. There would be no remaining uninsured State residents.
- Redistribution of health system financing would be greatest under this model. The state's entire health care system would be funded through government spending. Total government health care spending would increase by \$57.7 billion. Employer spending on health care would be eliminated, saving employers \$33.3 billion in aggregate. Individuals would save \$22.0 billion in total, with \$11.8 billion in savings accruing to those who spend the most on health care today, those over 400 percent of the FPL.
- Employers would no longer offer health insurance to their workers.

- There would be no private insurance market remaining in the state, so there would not be private insurance premiums.
- The aggregate change in health system spending under this reform is an additional \$2.4 billion dollars. This is a significantly smaller addition to system spending than is the case under the other approaches that achieve coverage for all with an individual mandate that rely significantly on a subsidized private insurance market. Savings as a consequence of the lower payment rates to providers and lower administrative costs that would be achieved through a fully government sponsored program are what permit a substantial increase in coverage with a smaller net increase in overall spending.
- We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services in the amount of \$402 million. This unmet demand would lower the health care spending from the estimates provided above. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

New York Health Plus Plan.

Simulation of Model 3-1: The New York Health Plus plan. Family Health Plus coverage is made available to all State residents. Employer assessment of 10 percent of payroll, which can be offset by employer contributions to workers' health insurance. Physicians permitted to collectively negotiate payment rates with health plans and the state. See summary Tables 1D-4D:

- Due to aggressive auto-enrollment efforts, this plan is expected to eliminate uninsurance in the state. The current non-group insurance market would be eliminated. Employer sponsored insurance would decline by 6.2 million people (almost a 60 percent reduction), as individuals move into Family Health Plus. Family Health Plus would enroll 7.4 million people, and an additional 1.7 million would enroll in Medicaid.
- Total gross government costs would increase by \$47.5 billion. The employer assessment raises \$13.6 billion to offset the new costs of the reform, leaving net government costs post-reform of \$33.9 billion. Even with the large assessment, employers save \$9.9 billion in aggregate due to the substantial decline in employer-based insurance. Individuals save \$17.9 billion in aggregate, owing to the large scale shift from private to public coverage.
- The employer insurance offer rates for workers in small firms decreases by 32.0 percentage points and by 27.1 percentage points in large firms.
- Employer based insurance premiums fall significantly for both small and large employers as higher than average cost individuals move from employer coverage to the new public plan. A private non-group insurance market would not remain post-reform.
- The aggregate change in health system spending under this approach would be \$6.1 billion. This program maintains some private sector coverage post-reform and cannot achieve the same level of payment rate savings as Model 2-1 due to the ability of providers to collectively negotiate.

- We estimate that, due to provider capacity constraints under this approach, there will be an unmet demand for services in the amount of \$1.0 billion. This unmet demand would lower the health care spending from the estimates provided above. This amount is higher than that under Public Health Insurance for All (Model 2-1) because provider payment rates are higher under this approach. However, the speed with which supply expands in the long run under New York Health Plus may also be faster as a result. It is uncertain how long it would take for provider supply to respond to the increase in demand for services.

Modified “Freedom Plan” Option.

Simulation of Model 4-1: Modified “Freedom Plan.” Introduction of high deductible policy into the private non-group market; increased rating flexibility in non-group products based upon health care risk; additional \$31 million contributed to state’s government-funded reinsurance for non-group market; subsidies for the purchase of small group and non-group policies (modeled as subsidies phased-in in year 3 post implementation, 15 percent of employer share in small group market and 15 percent of full non-group premium). See summary Tables 1D-4D:

- The net change in insurance coverage is very small in this model. Medicaid/CHIP coverage barely increases on net. While some uninsured enroll in Medicaid as a consequence of the expansion for children to 400 percent of the FPL (a reform already implemented in the State and included in each reform simulation in this report), others with Medicaid move out of the program and into employer-based coverage once the reforms are in place and employer sponsored premiums fall in the private market. Non-group coverage increases by 400,000 and employer-based coverage falls on net by a very small amount. While some gain employer coverage, others migrate to non-group coverage to take advantage of the new flexibility in premium rating rules. Also, a small share of large firm workers lose their offer of health insurance, and not all of those workers obtain coverage through non-group or Medicaid, becoming uninsured.
- One significant consequence of introducing a high deductible option into the non-group market is that positive risk selection into that new option undermines the comprehensive coverage product to such an extent that it is no longer viable in the marketplace. As a consequence, the high cost population enrolled pre-reform in more comprehensive non-group coverage would be faced with higher out-of-pocket costs when shifted to the new more parsimonious plans.
- Under this reform, the number of uninsured in the State declines by 15.4 percent. Post-reform, 92.6 percent of State residents either have coverage or are eligible public insurance (Medicaid/CHIP).
- Total government costs increase by \$2.7 billion. Employer spending falls by \$2.1 billion due to the subsidies for small employers. Individual spending increases post-reform by \$1.2 billion, with those costs accruing largely to those over 200 percent of the FPL.
- While the coverage effect is quite small, the government cost per newly insured person is quite high – \$6,605. The subsidy dollars directed to small employers and purchasers of non-group insurance largely go to those who were insured prior

to reform since the new government assistance is insufficient to attract many previously uninsured individuals or firms into the insurance market. The aggregate change in health system spending under this approach would be \$1.9 billion.