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HEALTH REFORM NEW YORK CAN AFFORD:

The Cornerstone for Coverage Plan

The Community Service Society Reports

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HEALTH REFORM NEW YORK CAN AFFORD: The Cornerstone for Coverage Plan

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& Arianne Garza

Inside this report:

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The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action that serves the needs of low-income New Yorkers. CSS draws on a 160-year history of excellence in addressing the root causes of economic disparity through research, advocacy, and innovative program models that strengthen and benefit all New Yorkers.

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Foreword

This report is being released at an extraordinary time. At the federal level, Congress and President Obama are grappling with a variety of proposals to expand coverage and reduce health care costs on a national scale. Prior to this national effort, the laboratories of the states—most notably Massachusetts, Maine, and Vermont—began pushing forward with their own coverage initiatives, filling the perceived federal health reform void.

In 2007, New York's Governor launched the Partnership for Coverage process, holding eight public hearings around the State, gathering input about New Yorkers' collective vision for State health reform, and hiring consultants to model the potential impact of various health reform proposals in New York. The Community Service Society of New York (CSS) participated in this process extensively. In order to focus State policy makers and other key stakeholders on the question of what affordable health care really means for New Yorkers, we designed our own vision for State-based reform—the Cornerstone for Coverage proposal described here—which builds upon New York's existing popular, affordable, and comprehensive public insurance programs.

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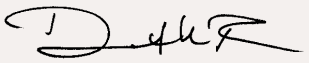


David R. Jones, Esq.
President & CEO, Community Service Society
November 2009

INTRODUCTION

More than two and a half million New Yorkers under the age of 65 are without health insurance, including nearly one in five adults between the ages of 19 and 64. Paying for care is increasingly difficult for New York's families. Between 2000–2009, health insurance premiums for family coverage in New York State rose 97 percent;[1] meanwhile, median earnings grew just 14 percent.[2] Nearly one in five working families in New York spend over 10 percent of their pre-tax income on health care.[3] While the high cost of health care does keep many people from getting the care they need, it doesn't keep them from getting sick.

The Cornerstone for Coverage ("Cornerstone") proposal seeks to provide high-quality, affordable health insurance to all uninsured New York residents for as little as $2.9 billion when fully implented. In these economically challenging times, Cornerstone offers a pragamatic approach to health security for New York.

Under Cornerstone, the typical moderate-income family of three (two adults and one child) with an annual income of $65,000 would be able to buy comprehensive coverage for $250 per month, just less than 5 percent of their gross family income. If this same family had an income over $110,000 per year, they would pay $800 per month, the full Cornerstone premium, or just below 9 percent of their gross family income. Employers, small businesses, and unions could participate in Cornerstone as well, allowing them to offer comprehensive, affordable coverage to their workers at a reasonable cost.

Building on New York State's purchasing power through its popular public insurance programs—Child Health Plus (CHP) and Family Health Plus (FHP)—Cornerstone offers affordable, high-quality health insurance to all New Yorkers, on a voluntary basis, through a choice of plans with comprehensive benefits and no hidden costs. As the nation and New York State sink deeper into fiscally challenging times, Cornerstone offers an incremental, and viable, approach to health reform. Just as New York's CHP program served as the blueprint for the nation's State Children's Health Insurance Program (S-CHIP), the Cornerstone proposal provides a historic opportunity for New York State to help formulate an innovative State-based approach to providing comprehensive, affordable health insurance coverage to all.

CORNERSTONE FOR COVERAGE

Employers: Cornerstone would offer employers the chance to buy in to the state's popular Family Health Plus and Child Health Plus programs for their employees by rapidly expanding the 2007 FHP Employer Buy-In program.

Individuals and Working Families: For individuals wishing to purchase this insurance on their own, Cornerstone offers a sliding-scale subsidy based on income to help working individuals and families buy in to FHP and CHP.

NEW YORK'S HEALTH CARE CRISIS

> **"Every year the cost of living goes up, insurance rates go up, and if you get a raise, if there is one, it goes towards the insurance. You never really get a raise to keep up with the cost of living."**
>
> – Small Business Owner from Rochester, NY

New York spends $126 billion annually on health care, nearly the highest per capita of any state in the nation.[4] Yet 14 percent of New Yorkers currently have no health insurance.[5] That is 2.6 million workers, families, and friends who are living with the daily risk of financial hardship, bankruptcy, or even premature death because they do not have access to affordable, comprehensive health care.

Uninsurance Rates and Health Costs are Rising Precipitously

And these numbers are growing. Across the nation, U.S. Census Bureau data indicate that the rate of employer-sponsored insurance is dropping.[6] This, in large part, is due to skyrocketing health care costs. Between 2000 and 2009, insurance premiums rose 6.4 times faster than median worker earnings.[7] CSS's most recent issue of *The Unheard Third*, an annual poll of New York City residents (where a little over half of the State's uninsured live), confirms a decline in the number of low-income workers who report receiving health insurance from their employer over the past seven years.[8]

CSS'S STATEWIDE HEALTH POLLS

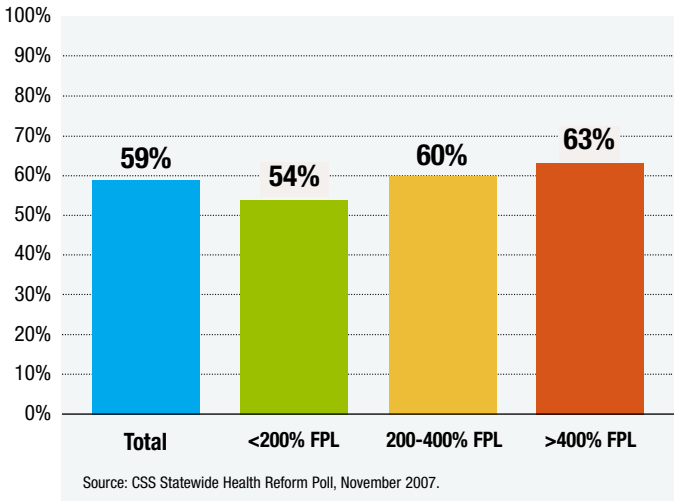
In November 2007, CSS and Lake Research Partners conducted a first-of-a-kind health poll of 1,619 New York residents in four regions (New York City, Long Island, Urban Upstate, and Rural Upstate) and across three income groups: below 200 percent of the federal poverty level, between 200–400 percent of the federal poverty level, and above 400 percent of the federal poverty level. In August 2009, CSS and Lake conducted a second Statewide Health Poll of 1,003 New Yorkers in the same regions.

For more about CSS's Statewide Health Polls, go to: **www.cssny.org**

Uninsurance Affects All Communities in New York State

Uninsurance is not confined to any one group or area of New York: It is a problem that touches many New Yorkers in all communities throughout the State. Statewide, three in five New Yorkers (59 percent)—regardless of income level—know someone who had been uninsured during the prior two years (see Figure 1).[9] In March 2009, researchers found that 5 million New Yorkers (one out of every three) had experienced a lapse in coverage during the year or no coverage at all between 2007 and 2008.[10] With the current economic crisis, tens of thousands more are being bumped onto the unemployment rolls, many with no affordable options for health care.

Figure 1: Percentage of New Yorkers who personally know someone who has been without health insurance in the last two years, by income.



Source: CSS Statewide Health Reform Poll, November 2007.

New York Has Expanded Coverage for Children: It's Time to Cover All New Yorkers

In 2008, New York expanded its public health insurance program for children—Child Health Plus (CHP)—to provide subsidized coverage to families up to 400 percent of the Federal Poverty Level (FPL) with a full-price

buy-in option for higher-income families through CHP. Nearly all New Yorkers can afford to get their children the health care they need. Yet, many parents and other uninsured adults still cannot afford insurance for themselves. The 2.2 million uninsured adults in New York represent 18 percent of the State's adult (19–64) population. Nearly half (45 percent) are low-income, earning less than 200 percent of FPL ($36,600 for a family of three).[11] Strikingly, 64 percent of uninsured adults are also employed, and 43 percent are working full time.[12]

Meeting the Needs of New York's Under-Insured

Nationally, estimates of the number of people who are **"under-insured"**—individual or families who spend more than 10 percent of their income on health care—range from 20–24 percent.[13] In New York State, 20 percent of the population, or 833,000 New Yorkers, are estimated to be "under-insured."[14] Increasing health care costs have forced many employers to shift costs onto their employees in the form of stripped-down benefits and increased co-payments (out-of-pocket fees paid for particular services) and co-premiums (the monthly share a person must pay for their health insurance).

In the Direct Pay, or individual, market, higher costs have also contributed to the rise of so-called "consumer-driven" products. These are insurance products that offer lower front-end costs offset by high cost-sharing (often in the form of high deductibles) and/or limited benefits. Many people are unaware that their insurance is inadequate until they encounter a serious illness, develop a chronic condition, or face a medical emergency, and their insurance fails to cover their medical needs. As a result, a significant number of people cannot access medically necessary care or do not have the financial means to obtain needed care, even though they are technically "insured."

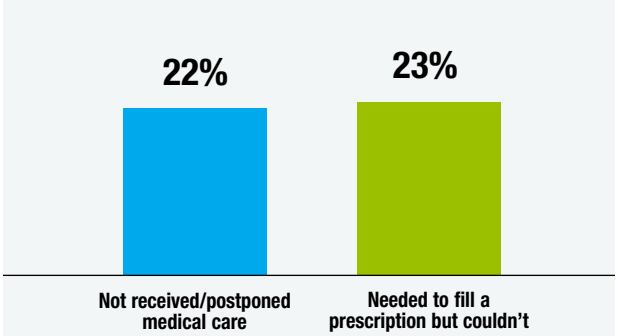
Inadequate Insurance Coverage Causes Health Hardships

According to a landmark study by the Institute of Medicine, people who are uninsured have a lower likelihood of receiving needed care for serious and chronic medical conditions.[15] The uninsured and under-insured are much more likely to delay or forgo needed care because of cost; 60 percent of the under-insured and 70 percent of the uninsured reported these problems, almost double the rate among those with adequate insurance.[16] As a result, many New Yorkers are getting sicker and dying sooner simply because they have inadequate health insurance.

The increase in health costs and the number of those who have inadequate health coverage or none at all means that many New Yorkers are now making the difficult decision between paying for their health care or paying for other household necessities such as food, gas, or rent. CSS's 2009 Statewide Health Reform Poll found that 22 percent of New Yorkers had not received or postponed getting medical care or surgery because of a lack of money or insurance; and 23 percent had failed to fill a prescription for the same reasons (see Figure 2).[17] These findings validate other research indicating that high cost-sharing (co-premiums and co-payments) presents a significant challenge to obtaining coverage, and that even modest cost-sharing can discourage people from seeking necessary health care services.[18]

> "I don't usually go to the doctor because I can't afford to pay for the appointment or the tests I need to have done. It is very discouraging…"
>
> - Voter from Binghamton, NY

Figure 2: Percent of New Yorkers forgoing medical care and prescriptions due to lack of money or insurance, 2009.



Source: CSS Statewide Health Reform Poll, August 2009.

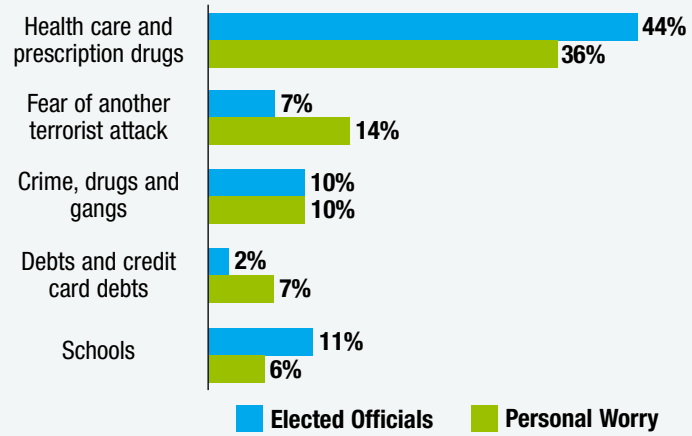
Inadequate Insurance Leads to Debt and Bankruptcy

In addition to causing health hardships, lack of adequate insurance can also have dire consequences for families' financial stability and economic future. In some cases, limited benefits can force desperate patients to pay out-of-pocket for the full cost of their care or forego it entirely.[19] Working-age adults are now at higher risk of debt due to unaffordable medical bills.[20] Medical bills account for more than 60 percent of all families filing for bankruptcy in 2007, up from under 50 percent in 2001.[21] One study found that medical debt is increasingly correlated with home foreclosures.[22]

It's Time to Act on Health Reform

New Yorkers report that health care and prescription drugs are their top personal worry and the number one issue they want their elected officials to act upon (see Figure 3). When asked, fully 65 percent said they would be more likely to re-elect State legislators who support a health reform proposal covering all New York residents. In fact, three in five residents reported worrying more about the government taking no action on this issue than about higher taxes and increased government control.

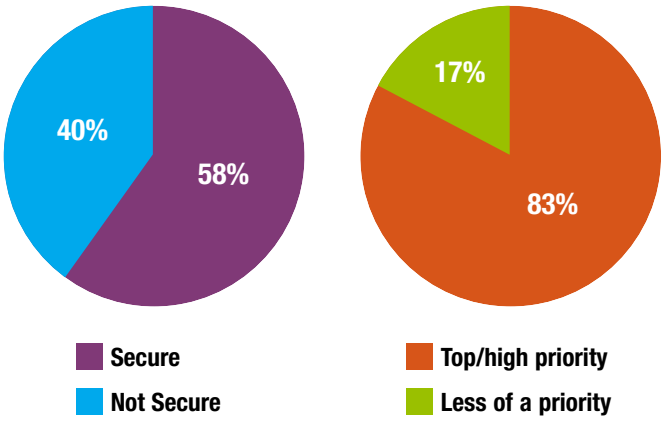
Figure 3: Issues identified by New Yorkers as their top personal worry, and the top issue they want elected officials to address.



Truncated list, top 5 issues only.
Source: CSS Statewide Health Reform Poll, November 2007.

In August 2009, CSS again polled New Yorkers and found that 40 percent of New Yorkers do not feel financially secure to meet their future health needs and fully 83 percent felt that making health care more affordable should be a top or high priority for their elected officials (see Figure 4).

Figure 4: New Yorkers' views on their health security and the political priority of making health care affordable.



Source: CSS Statewide Health Reform Poll, August 2009.

THE CASE FOR AFFORDABLE HEALTH REFORM

> **"Working families are the core. You have children in college and you're trying to pay for groceries. We make a very decent salary and money is just flying out the window. You can't get ahead. You put money away and then something comes up."**
>
> - Voter from Buffalo, NY

Making health insurance and health care affordable is the lynchpin to successful health reform in New York, where nearly half of the uninsured live at or below 200 percent of the federal poverty level ($36,600 for a family of three). The escalating cost of health care is increasingly beyond the means of most New York families.

When costs are viewed in terms of what a family can *afford*—the percentage of income a household can devote to health care, while still having sufficient income to address other basic needs—it is possible to design a healthcare program that is truly accessible to all.[23]

The Reality in New York: Few Affordable Choices

For most adult New Yorkers who have moderate or higher incomes, there are three options for getting health insurance coverage: (1) the individual Direct Pay market; (2) Healthy New York; or (3) employer-sponsored insurance.

New York's Individual Market is Cost-Prohibitive

New York is one of the few states in the nation which requires health insurance companies to offer coverage on the Direct Pay, or individual, market to all New Yorkers, regardless of their age, gender, or health status. Because New Yorkers purchasing this coverage are more likely to be sick or have disabilities, the cost of this insurance is very high. Since 2000, New York has subsidized the cost of such coverage through a reinsurance pool. Unfortunately, reinsurance funding for New York's Direct Pay market has not been increased since 2000, and in fact was cut by 6 percent in the fall of 2008.

As a result, individual coverage is cost prohibitive for most New Yorkers, where the average annual cost of the least expensive available comprehensive health coverage in the Direct Pay market is approximately $12,000 for an individual and $24,000 for family-based coverage.[24] As Table 1 demonstrates, these amounts are well beyond the budget of most working families. For example, Direct Pay insurance premiums constitute 130 percent of family income at the poverty level. Even for a family of four making $88,000 per year (400 percent of FPL), purchasing a Direct Pay policy would take up 33 percent of the family's gross income. Because of these high costs, and diminished State support, participation in the individual Direct Pay market has plummeted by more than 50 percent—from 111,000 members in 2000 to 45,600 enrollees in 2007.[25]

Healthy NY: Poor Value for the Cost

The State's Healthy New York (Healthy NY) program provides an alternative for individuals (and families), sole proprietors, and small businesses with a substantial share of their employees earning less than 250 percent of FPL. Currently, there are more than 150,000 enrollees in this program.[26] As of 2001, under Healthy NY, health plans operating in New York are required to offer a uniform limited benefit plan to individuals, small groups, and sole proprietors who meet certain eligibility requirements. Enrollees experience substantial cost-sharing in the form of higher deductibles and co-payments than they would face in the Direct Pay market. The State heavily subsidizes the Healthy NY program through a reinsurance pool that pays for all claims between $5,000 and $75,000. Despite this significant State subsidy, and the relatively limited benefits provided, Healthy NY remains cost-prohibitive for most working New Yorkers targeted by the program, consuming as much as 31 to 45 percent of an individual or family's income (see Table 1).

Employer-Sponsored Insurance: Feeling the Economic Squeeze

Most adult New Yorkers get health insurance through their jobs, referred to as "Employer-Sponsored Insurance" (ESI). Fifty-eight percent of New Yorkers below the age of 65 are covered through ESI.[27] ESI typically consumes between 2 and 9 percent of an individual's income (see Table 1).

Yet, as described in Table 1, there are no affordable options for those low- and moderate-income families (above Medicaid income eligibility levels) who cannot

Table 1: Percent of Pre-Tax Family Income Consumed By Different Health Insurance Options.

Federal Poverty Level	2009 Income	Single Adult			
		Direct Pay	HNY	ESI	Cornerstone
100%	$10,800	79%	31%	9%	0%
200%	$21,700	40%	15%	5%	2%
300%	$32,500	26%	10%	3%	2%
400%	$43,300	20%	8%	2%	3%
500%	$54,200	16%	6%	2%	4%
600%	$65,000	13%	5%	2%	6%
Federal Poverty Level	**2009 Income**	**Family of Four (2 Adults 2 Children)**			
		Direct Pay	HNY	ESI	Cornerstone
100%	$22,100	131%	45%	17%	0%
200%	$44,100	65%	22%	8%	2%
300%	$66,200	44%	15%	6%	3%
400%	$88,200	33%	11%	4%	5%
500%	$110,300	26%	9%	3%	5%
600%	$132,300	22%	7%	3%	9%

Source: CSS Analysis: ESI Data from MEPS/IC (2006); Direct Pay data calculated based on NYSDOI Premium Rates Index (April 2008); HNY data derived from NYSDOI - 2007 Annual Report on Healthy New York. All costs adjusted to 2009 dollars based on observed premium cost growth in each program (ESI, Direct Pay and Healthy NY).

access ESI. Built on a sliding-fee scale geared towards a family's income, Cornerstone is designed to address this reality.

What is Affordable?

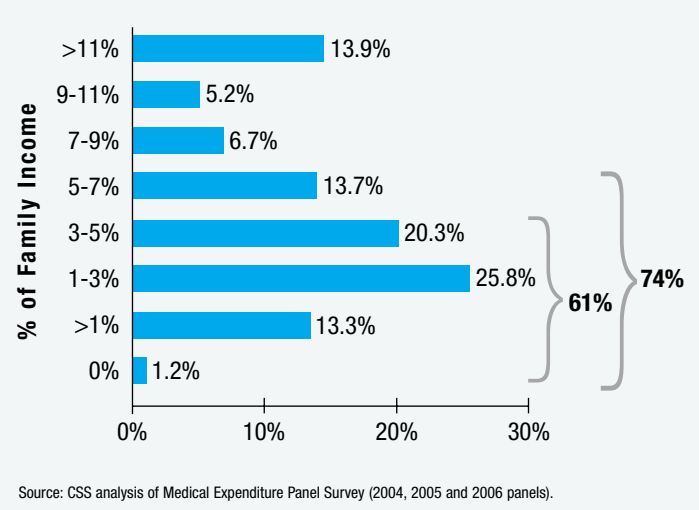
If health coverage is to be really available to all, it is important for health insurance costs to be a reasonable share of family income. But what level of health costs should be considered affordable?

Researchers have approached this question in a number of ways in an effort to set realistic affordability thresholds. One way to measure affordability is to observe what people are already spending for health care. Another way is to survey families about what they would be willing to pay for health care, or what costs they believe are reasonable.[28]

What are New Yorkers Currently Paying for Health Coverage?

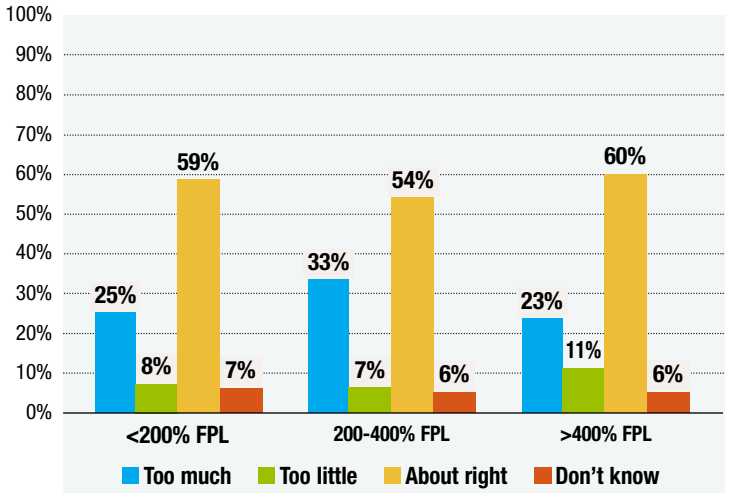
Since most people obtain health insurance through their employer, the average cost of ESI provides insight into what it means for health insurance to be affordable. For example, of families between 150–500 percent of FPL who have ESI from a current employer, the majority (57 percent) contribute less than $200 a month for health insurance for their family coverage, and three quarters (73 percent) contribute less than $300 a month. Singles pay even less: Two-thirds (67 percent) pay less than $100 a month towards their individual coverage, and 79 percent pay less than $150.[29] The majority (61 percent) of families with ESI coverage spend less than 5 percent of their gross family income on their total health expenses (monthly premiums plus out-of-pocket costs), and three-quarters pay less than 7 percent (see Figure 5).[30]

Figure 5: Health Care spending as a percent of family income for the Northeast region, 2009.



Source: CSS analysis of Medical Expenditure Panel Survey (2004, 2005 and 2006 panels).

Figure 6: Most New Yorkers feel spending 5 percent of their pre-tax income on health care is about right, by income.



Source: CSS Statewide Health Reform Poll, November 2007.

Quantitative Survey of New York Families About What they Can Afford to Pay

Another way to measure affordability is to ask people what they think is an affordable health insurance premium. In CSS's 2007 Statewide Health Reform Poll of 1,619 New Yorkers, respondents were asked: (1) whether 5 percent of gross family income is a reasonable amount to pay for health care; (2) what they are currently paying; and (3) what specific premium rates they would be willing to pay.

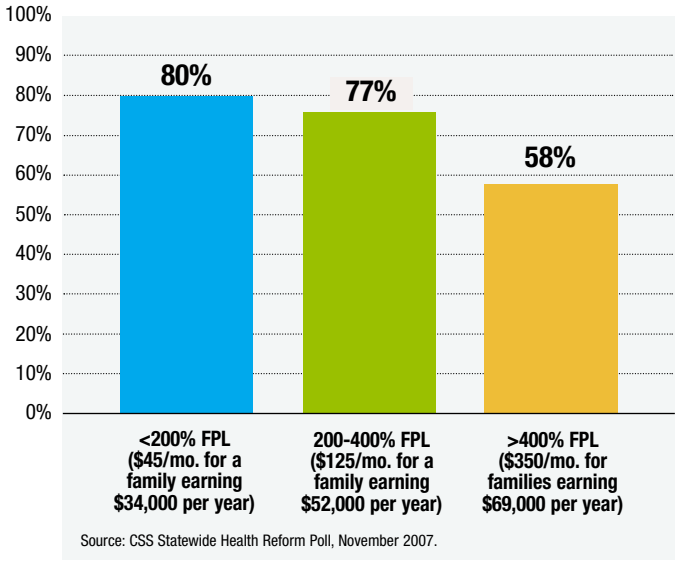
First, CSS found that a majority (57 percent) of New Yorkers at every income level said that paying about 5 percent of their before-tax income on health care was about right; 27 percent of New Yorkers thought it was too much; and only 9 percent of New Yorkers thought it was too little (see Figure 6).[31] Respondents with children were much more cost sensitive on this question, with 36 percent of parents saying that spending 5 percent of their pre-tax income was too much.

Second, CSS asked New Yorkers how much they currently spend on health coverage and how much they thought they could afford. Most respondents reported that they have very little flexibility in their budgets for health coverage. CSS found that, on average, New Yorkers said that they could afford to spend around $190 per month on health insurance coverage, and that they were currently spending around $163 per month on health coverage.[32] In August 2009, CSS found that these levels had increased slightly: New Yorkers reported they could afford to spend $206 per month on health insurance, and were currently spending around $182 per month.[33]

Finally, CSS asked a series of pricing questions, geared to the sample at three different income levels: below 200 percent of FPL; between 200 and 400 percent of FPL; and above 400 percent of FPL. CSS developed the pricing questions based on a progressive sliding-fee scale that builds off of the schedule used in the State's Child Health Plus program, and which would eventually be adopted in the CSS Cornerstone proposal. CSS found that 80 percent of people below 200 percent of FPL

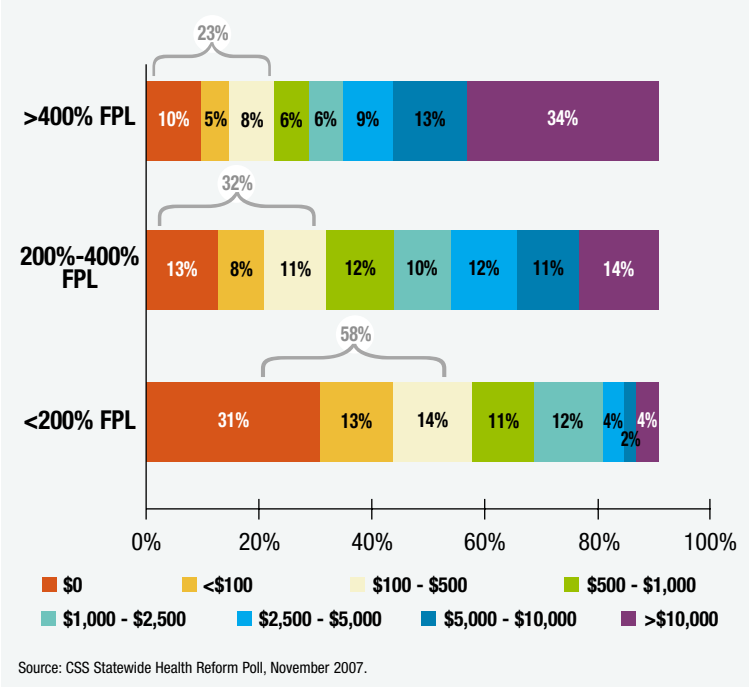
favor charging families making around $34,000 a year $45 per month for health insurance; 77 percent of people between 200 and 400 percent of FPL favor charging families making around $52,000 a year $125 per month for health insurance; and 58 percent of families above 400 percent of FPL favor charging families making around $69,000 a year $350 per month for health insurance (see Figure 7). Support for these price points at all three income levels was strongest in rural upstate New York.[34]

Figure 7: Percent of New Yorkers who agree to charging Cornerstone premiums to families at their own income level.



CSS also explored the level of savings in each of the households surveyed. Even before the current economic downturn, New Yorkers reported having very little flexibility in their budgets. Nearly a third (31 percent) of those earning less than 200 percent of FPL reported having nothing to fall back on in hard times. The majority (58 percent) had less than $500 in savings. Strikingly, a third (32 percent) of moderate-income New Yorkers earning between 200–400 percent of FPL had less than $500 to fall back on.

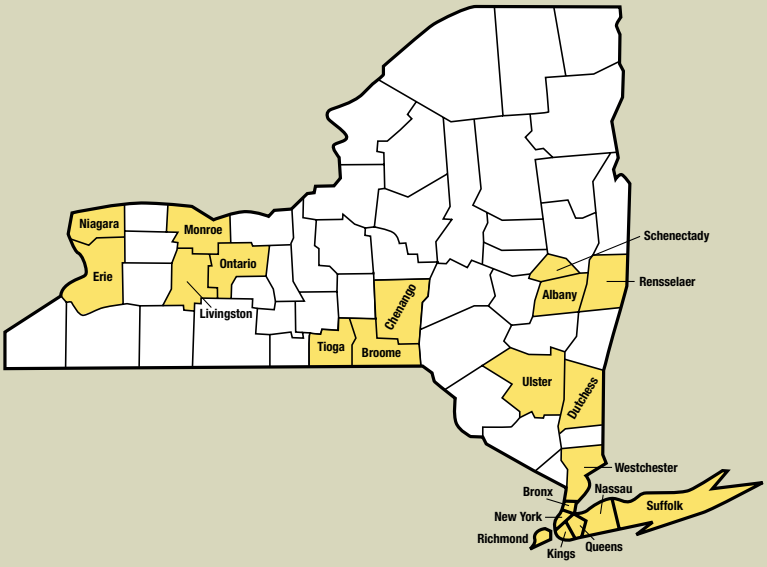
Figure 8: Amount of savings New Yorkers say they have to fall back on, reported by income.



A Typical Family Budget in New York

Working with partners across the state, CSS held a series of workshops and interviews with 258 New York families in 21 counties (shaded in yellow in the map below) to help us understand affordability as people experience it in their daily lives. We asked New Yorkers to tell us how they spend their income. We found that health care "affordability" is more than just a question of whether a working family can pay monthly insurance premiums; rather, it is a question of what a family will have to give up in order to do so.

Federal and state policy makers urge the adoption of affordability caps to protect Americans who will be required to purchase health coverage. Some say that families earning less than 400 percent of FPL (or $73,240 for a family of three) would have to pay up to 12 percent of their gross family income on health care premiums. But this prescription is bitter medicine for New York's working families.



The box below shows a typical budget for a family of three at 350 percent of FPL in New York City. This family would be mandated to spend no more than 12 percent of their income on health care. But under this mandate, the affordability cap is too high to protect this family because they are left with insufficient income for other household needs and, in fact, will be left in debt. Even if the affordability cap was reduced to 11 percent, this working family would have only $50 remaining at the end of the year to spend on other household needs such as clothing, school supplies, and toiletries.

Family of Three (Two Adults and one child) earning 350% of FPL and living in NYC

Gross Yearly Pay:	$ 64,085
Taxes:	$ 15,311
Net Pay:	**$ 48,774**
Rent:	$ 15,012
Child Care:	$ 10,571
Food:	$ 8,868
Utilities:	$ 4,368
Transportation:	$ 2,856
Health care premiums:	
(cap at 11% of income)	$ 7,049
(cap at 12% of income)	$ 7,690
Remainder (at 11%):	**$ 50**
Remainder (at 12%):	**$ (591)**

Does not include other essential expenses such as clothing, school supplies, toiletries, and so forth.

Sources: Taxes are based on NYC residency with federal withholding exemptions of three for a three person family. Rents are based on average NYC rents for income bracket, for people who have moved in 2005 or later as set forth in the 2008 NYC Housing and Vacancy Survey. Child care and food costs taken from 2004 NYC Self-Sufficiency Standard for the City of New York, adjusted to 2008 dollars using the Consumer Price Index. Utilities and transportation costs are the average of amounts reported by five New York City families with children. Health costs calculated from range determined by Senate HELP Committee and House Tri-Committee affordability schedules. See Kaiser Family Foundation Side-by-Side Comparison of Major Health Reform Proposals, available at http://www.kff.org/healthreform/sidebyside.cfm

THE CORNERSTONE FOR COVERAGE PROPOSAL

Can Mandates Help Make Coverage Affordable?

Proponents of an individual insurance mandate argue that if everyone is required to purchase insurance, more healthy people will join the insurance pool. These healthy participants will bring down the cost of coverage for everyone by offsetting the costs of the more expensive, sicker people who currently have a greater incentive to purchase coverage than the healthy. But the lone real-world experience of mandates, in Massachusetts, tells us that they only work where coverage is affordable.

In 2006, Massachusetts implemented a State-based health reform measure which offered subsidized coverage to people up to 300 percent of FPL, and mandated all residents, regardless of income, to obtain or purchase health insurance. As a result of the mandate, individual market premiums declined between 25–30 percent. But since the plan's implementation, nearly 20 percent of the State's uninsured population between 300–500 percent of FPL had to be exempted from the individual mandate because State subsidies stopped at 300 percent of FPL and there were no affordable insurance options on the market available to them.[1]

According to a CSS analysis of New York State Department of Insurance data, if a similar proposal were adopted in New York, as many as 500,000 people would be left uninsured, *after* health reform, simply because health insurance will still be unaffordable for many New Yorkers.[2]

1 Dembner, Alice. "Health Plan May Exempt 20% of the Uninsured." Boston Globe. April 12, 2007.
2 CSS. "Estimates of Uninsured Adults in New York State Subject to Affordability Waiver under a Coverage Mandate," Unpublished, August 2009.

Cornerstone for Coverage ("Cornerstone") is a voluntary plan that would offer high-quality, affordable, comprehensive coverage to all New Yorkers. Under Cornerstone, individuals and families would never pay more than 9 percent of their gross family income for health coverage.

Cornerstone for Coverage builds on New York's extremely popular public insurance programs—Child Health Plus and Family Health Plus—to ensure that coverage:

- Is available to all New York families, individuals, employers and unions.
- Offers high-quality, comprehensive care through a choice of plans.
- Offers affordable coverage through sliding-fee scale premiums with no hidden deductibles or co-pays.
- Is voluntary for any New Yorker who wants coverage.
- Leverages the State's public health insurance plan purchasing power to benefit individuals and employers.

In order to ensure that New Yorkers would not pay more than 9 percent of their gross family income for health coverage, Cornerstone is built along a sliding-fee scale. Individuals and families with high income would be able to purchase coverage at full cost.

In short, Cornerstone would make high-quality, affordable health insurance accessible to all of New York's residents and businesses. CSS estimates that if Cornerstone were to be implemented, as described in this report, an additional 1.4 million New Yorkers (including 920,000 uninsured) would choose to voluntarily sign up for health coverage under the program over five years.

Features of the Cornerstone Proposal

All New Yorkers Would be Eligible

Cornerstone would be available to all children, adults, and employers in New York. By extending the residency rules of the existing CHP program to all New York adults, every New Yorker below the age of 65 would be given the option to participate in the program with sliding-scale premiums based in income.[35] The recently enacted employer and union buy-in to the FHP program would be available to all employers in New York State. This would allow all employers and small businesses to leverage the purchasing power of the State to get affordable coverage for their workers.

Cornerstone extends the existing rules in the State's CHP program. As with CHP, all uninsured New York State residents up to age 65 would be eligible on a sliding-scale basis, regardless of immigration status.

Comprehensive Benefits Would be Included

The Cornerstone proposal would offer the same benefit package that is currently offered to individuals in FHP, through authorized managed care plans. These services include:

"Given the high taxes in New York State, [Cornerstone] might help bring businesses back to New York. And it could help to lower taxes because more businesses are paying into the system."

– Small Business Owner from Buffalo, NY

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

Affordable Co-Premiums Without Hidden Co-Payments or Deductibles

Cornerstone would introduce progressively staged co-premiums based on household size and income into the FHP program for individuals and families above 160 percent of FPL (see Table 2). It would also raise the FHP income eligibility threshold for subsidized coverage from 100 percent of FPL for childless adults and 150 percent of FPL for parents to 600 percent of FPL across the board. This would allow middle-income families to leverage the State's purchasing power to access subsidized coverage. In addition, higher-income individuals and families not eligible to receive the subsidy would be given the option to buy in to the program at full cost. The CHP program would also be expanded to offer subsidized coverage up to 600 percent of FPL (up from 400 percent of FPL), with a full-cost buy-in option above 600 percent of FPL.

Using Cornerstone's proposed sliding-fee scale, individuals or families earning less than $17,300 for a single adult or $29,300 for a family of three (160 percent of FPL) would be able to enroll in the Cornerstone program free of charge. A family of three (two adults and one child) earning $50,000 would pay $125 per month for their health care coverage. An individual earning $30,000 would pay $50 per month.

These subsidized premium levels amount to no more than 9 percent of a family's gross income at any income level (see Table 3).[36] As in the CHP program, family maximum co-premiums would also be implemented. Proposed family maximum co-premiums would equal the cost of two adults and one child or one adult and four children. Consequently, larger families would not

Table 2: Cornerstone Monthly Premiums [Year 1–2009]

	Individuals		Families (Two Adults + One Child)	
% of Federal Poverty Level	Yearly Income Range	Monthly Premium	Yearly Income Range	Monthly Premium
<160%	< $17,300	**Free**	< $29,300	**Free**
161–222%	$17,300–$24,000	**$18**	$29,300–$40,600	**$45**
223–250%	$24,000–$27,100	**$30**	$40,600–$45,800	**$75**
251–300%	$27,100–$32,500	**$50**	$45,800–$54,900	**$125**
301–350%	$32,500–$37,900	**$70**	$54,900–$64,100	**$175**
351–400%	$37,900–$43,300	**$100**	$64,100–$73,200	**$250**
401–500%	$43,300–$56,900	**$140**	$73,200–$96,100	**$350**
501–600%	$56,900–$65,000	**$200**	$96,100–$109,900	**$500**
>600%	> $65,000*	**$320** [Full Premium]	> $109,900*	**$800** [Full Premium]

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

Table 3: Cornerstone Premiums as a Percent of Family Income.

Family Income Group	1 Adult	1 Adult + 1 Child	1 Adult + 2 Children	2 Adults	2 Adults + 1 Child	2 Adults + 2 Children	2 Adults + 3 Children
<160% FPL	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
160–222% FPL	1.2%	1.4%	1.5%	1.9%	1.8%	1.5%	1.3%
223–250% FPL	1.5%	1.7%	1.8%	2.2%	2.2%	1.8%	1.6%
251–300% FPL	2.2%	2.5%	2.6%	3.3%	3.3%	2.7%	2.3%
301–350% FPL	2.6%	2.9%	3.1%	3.8%	3.8%	3.2%	2.7%
351–400% FPL	3.2%	3.5%	3.7%	4.7%	4.7%	3.9%	3.3%
401–500% FPL	3.9%	4.3%	4.6%	5.8%	5.7%	4.8%	4.1%
501–600% FPL	4.4%	4.9%	5.2%	6.6%	6.6%	5.4%	4.7%
> 600% FPL*	≤5.9%	≤6.6%	≤7.0%	≤8.8%	≤8.7%	≤7.3%	≤6.2%

bear additional co-premium costs above this level. Because the federal poverty level is dependent upon family size, the percentage of a family's gross income that the family maximum co-premium represents gets smaller as the family size gets bigger (see Table 3).

Under New York's current income limits for the FHP program, individuals above 100 percent of FPL and families above 150 percent of FPL who experience a marginal increase in income that bumps them above the income eligibility threshold can go from paying no co-premium for FHP insurance to as much as $1,000 or more per month in the Direct Pay market. Cornerstone's sliding-fee scale would effectively eliminate these income cliffs and ensure that coverage is affordable for all families. It's also consistent with what most working families in New York currently pay for their total medical expenses (premiums and out-of-pocket costs) through their employer-sponsored coverage.[37]

Cornerstone has very modest co-payments with no hidden costs or deductibles. The co-payment structure is based on the current co-payment levels in the FHP program, which vary depending on type of services, usually ranging from $3 to $25. As with the current CHP and FHP programs, there are no co-payments for children or pregnant women.

Cornerstone Helps Employers and Small Businesses

Cornerstone utilizes New York's existing health infrastructure to help employers, unions and small businesses. In 2007, New York authorized the establishment of the Employer Partnerships for Family Health Plus, or the FHP Employer Buy-in program, which permits employers and union funds to purchase coverage through the FHP program.[38] In 2008, the program was piloted for the SEIU/Local 1199 home care workers. The State Department of Health has opened the FHP Employer Buy-in program to all employers and unions as of late 2009.

The Cornerstone proposal expands the FHP Employer Buy-in program. All employers and small businesses in New York would have the option to offer affordable coverage to their employees (and their families) through the State's contractual network of private and not-for-profit public insurance plans that participate in FHP and CHP. As with the individual program, any employee that meets FHP eligibility guidelines would also be entitled to a State subsidy. This would enable small businesses and other employers who cannot otherwise afford to offer coverage to their employees to take advantage of the lower rates that the State negotiates, and offer their employees a choice of managed care plans at an affordable price.

Through Cornerstone, employees would pay the same monthly co-premium as they would if they enrolled in FHP without their employer's participation, and employers would pay the remainder up to a maximum required employer contribution of 70 percent. However, at any time an employer can elect to pay more (or all) of its employees' share of the premiums.[39] The State would pay the differential, if any (see Table 4).

Like traditional employer-sponsored health plans, employers who choose to buy in to the program will facilitate enrollment for their employees. This would reduce the administrative burden on employees (and the State) and increase the likelihood of individuals signing up for the program.

Under Cornerstone, both the individual and Employer Buy-in programs are completely portable. An employee would see no rise in their monthly premiums due to a job loss or transition, nor would he or she experience an interruption in coverage. In the case of job loss, the employee would continue to pay their subsidized share of the monthly premium, and the remainder (if any) would be paid by the State. In the case of job transition, the employee may have the option of signing on to a different employer-sponsored plan (if offered), or keeping coverage under Cornerstone.

Table 4: Cost-sharing in the Employer Buy-in Program.

Proposed Employer Buy-in Cost-sharing—Single Adult [Year 1 – 2009]

Employee Family Income	Maximum Monthly Income	Monthly Enrollee Co-Premium, (% of Total Premium of $320.11)	Employer Share of Total Premium	Estimated State Share of Total Premium
0–160% FPL	$1,400	No Co-Premium	70%	30%
160–222% FPL	$2,000	$18 (6%)	70%	24%
223–250% FPL	$2,300	$30 (9%)	70%	21%
251–300% FPL	$2,700	$50 (16%)	70%	14%
301–350% FPL	$3,200	$70 (22%)	70%	8%
351–400% FPL	$3,600	$100 (31%)	69%	0%
401–500% FPL	$4,500	$140 (44%)	56%	0%
501–600% FPL	$5,400	$200 (62%)	38%	0%
>600% FPL	>$5,400	Full premium	0%	0%

Limiting Large Transfers from Private to Public Health Coverage—Addressing "Crowd Out"

Cornerstone has two primary features to address "crowd out," or the possibility of current ESI enrollees dropping private coverage in favor of the Cornerstone plan.[40] First, Cornerstone adopts a reasonable waiting period; and second, it includes enrollee cost-sharing roughly equal to ESI levels.

The Cornerstone proposal maintains the current waiting-period rules, established under State law for both New York's public insurance programs and individual Direct Pay market.[41] New York's CHP program and Direct Pay insurance law both prescribe six-month waiting periods for children and adults seeking to switch coverage; the FHP program has a nine-month waiting period for adults who have existing private coverage. However, in the public health insurance context, these waiting periods are waived in the following cases: there is no waiting period for those who lose employer coverage involuntarily, through loss of job, death in the family, move to a job that does not offer coverage, or if there is an expiration of COBRA benefits; for those whose job-based or COBRA costs are more than 5 percent of their gross family income; or for pregnant women or children under the age of five years.

The proposed Cornerstone premiums also act as a crowd-out limiting feature because the progressively-scaled premiums meet or surpass average costs of ESI in the upper income ranges. Low-income workers are less likely to be offered or take up ESI if offered it, so the Cornerstone premium structure remains low to ensure affordable access to these populations (a higher proportion of whom are uninsured).[42] At higher income levels, the rate of ESI offers and take-up is much higher, meaning that there is a high likelihood of crowd out. However, under the Cornerstone plan, as incomes increase, the percentage of gross family income that the premiums

"I think [Cornerstone] would make for happy employees because I would be able to offer it to them. I don't have a big turnover now but in our line of work we need to keep people on the routes for as long as we can and I think that would really help."

– Small Business Owner from Rochester, NY

represent increases as well. In many cases, and particularly at higher income levels, co-premiums under Cornerstone will be equal to or more than the current amount an employee pays under their ESI. This rate structure provides little financial motivation for employees to drop current ESI for Cornerstone coverage.

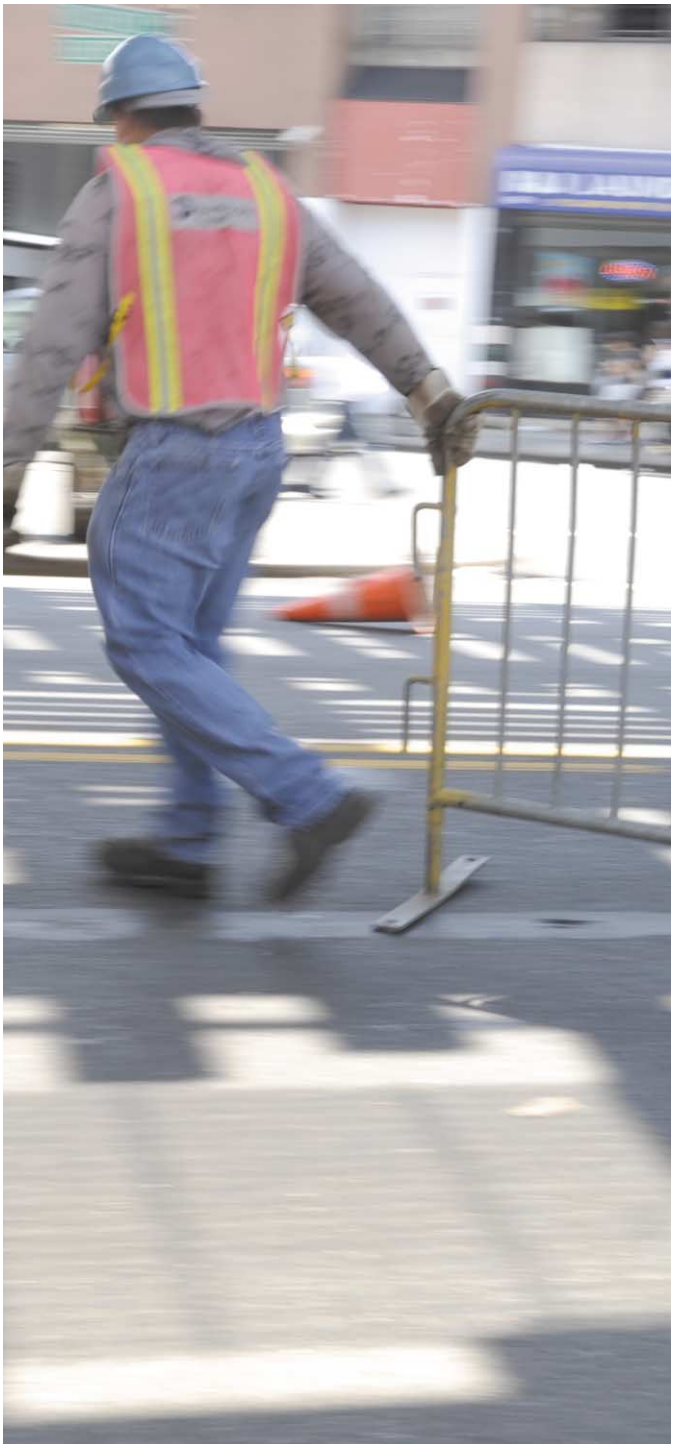
Enrollment and Cost Projections for Cornerstone

CSS anticipates a staged roll-out of Cornerstone. When fully implemented in Year 5, 1.4 million New Yorkers will be covered under the program, including 883,600 newly-eligible uninsured adults and 34,200 newly-eligible uninsured children, at a total government cost of $4.8 billion.[43] Cornerstone will expand gradually. The following section of this report describes the estimated enrollment and costs to the State and federal government.

Projected Enrollment in Cornerstone

Four major population groups are likely to participate in the Cornerstone program: (1) the currently uninsured; (2) individuals purchasing coverage in the Direct Pay market; (3) the individuals and sole proprietors enrolled in Healthy NY; and (4) those currently covered under ESI. Each of these four groups has unique characteristics requiring a separate take-up analysis for each group, which is briefly described below.

- **Current Uninsured:** Under Cornerstone, 1,519,000 currently uninsured adults will become newly eligible for coverage under FHP.[44] Enrollment among newly-eligible uninsured adults is estimated to be 56 percent, or 855,000, by Year 5. This accounts for both adverse selection and the affordability of the monthly premium.[45] With the addition of newly-eligible low-income immigrants (28,600) and newly eligible children between 400 and 600 percent of FPL (34,200), approximately 917,900 previously uninsured adults and children will enrollee in Cornerstone by Year 5.
- **Direct Pay:** Currently, 75,700 adults are enrolled in health insurance through New York's Direct Pay market.[46] The healthiest individuals are the most likely to switch programs if offered a lower premium, and the least healthy are most likely to stay in their current program regardless of premium differences. Since the cost of health insurance is quite high on the Direct Pay market and costs for the Cornerstone program can be as much as 70 percent lower, an estimated 98 percent of the Direct Pay population, or 74,200 adults, will transition to coverage under Cornerstone by Year 5.[47]
- **Healthy NY:** As of September 2007, approximately 101,700 individuals and sole proprietors were enrolled in Healthy NY, 81,400 of which are adults and 20,300 of which are children.[48] Under Cornerstone, Healthy NY for individuals and sole proprietors would be merged into the larger Cornerstone program. Thus, all those enrolled in the individual and sole proprietor program in Healthy NY would enroll into Cornerstone, leaving only small business groups in Healthy NY.[49] Approximately 101,700 enrollees previously in Healthy NY would join Cornerstone at Year 1.
- **Employer-Sponsored Insurance:** Despite significant crowd-out limiting factors, a significant number of individuals currently covered under employer-sponsored insurance can be expected to transition to public coverage under Cornerstone.[50] The likelihood of such a transition decreases as income increases, as higher-income families generally exhibit lower elasticity of demand (price responsiveness). Based on a detailed analysis of Medical Expenditure Panel Survey (MEPS) data using an elasticity of demand algorithm that varies by income level, an estimated 313,300 individuals (301,200 adults and 12,100 children) currently covered by ESI will join Cornerstone by Year 5.



CSS estimates that at full implementation (Year 5), expected enrollment under Cornerstone will be 1,407,000 (see Table 5). A more detailed description of take-up and enrollment projections is available in Appendix A.

Table 5: Cornerstone Enrollment at Full Implementation, by Prior Coverage Group.

Cornerstone Enrollment at Year 5	
Currently Uninsured	917,855
Direct Pay	74,176
Healthy NY	102,702
Employer-Sponsored Insurance	313,255
TOTAL Enrollment	**1,406,987**

Projected Cost of Cornerstone

In order to estimate how much Cornerstone would cost, CSS worked with Manatt Health Solutions, Milliman Actuarial, and Gorman Actuarial to develop estimated premium levels under Cornerstone. An overview of this analysis can be found in Appendix B. CSS estimates that premiums will gradually increase over the first five years of implementation of the Cornerstone Proposal (see Table 6).

Table 6: Projected Adult Premium Cost by Year of Program Implementation.

Overall Projected Premium Cost by Year		
Year	Adult	Child
Year 1	$320	$159
Year 2	$341	$153
Year 3	$360	$153
Year 4	$379	$156
Year 5	$398	$159

Based on the projected premium levels, the cost of extending FHP to the adult population below 600 percent FPL was calculated by applying the projected premiums to the total population of new enrollees.[51] From this amount, we calculated total cost-sharing offsets from enrollee co-premiums (including the impact of the offset for the family maximum), and total employer contributions. The total cost of Cornerstone—the difference of total premium costs minus cost-sharing and direct program offsets—is estimated to be $4.8 billion in Year 5.[52] See Appendix C for a description of cost-sharing and program cost offsets. Table 7 summarizes the cost estimates by year of program implementation.

It is possible that New York State will be able to access federal matching funds to cover part of the cost of the program. Based on current program rules, it is likely that potential federal contributions for the proposed eligibility expansions will range from zero to 50 percent of total government costs for certain legal-immigrant and citizen adults, and zero to 65 percent for children, with no federal contribution for undocumented children and adults. Table 8 reflects the total cumulative governmental costs for the proposed public insurance expansions under Cornerstone, showing both the maximum and the minimum federal match.

Table 7: Total Cornerstone Costs, Years 1–5.

	Summary of Costs by Payer by Year					
			Costs by Payer (Millions)			
	Total New Enrollees	Total Premium Cost (Millions)	Family Cost-sharing	Employer Cost-sharing	Offsets (HNY + Emergency Medicaid)	Total Government Cost
Year 1 (2009)	426,592	$1,468.2	$187.6	$39.7	$140.4	$1,100.4
Year 2 (2010)	879,147	$3,269.7	$450.3	$102.1	$206.1	$2,511.1
Year 3 (2011)	1,204,037	$4,741.2	$638.0	$153.6	$271.8	$3,677.9
Year 4 (2012)	1,337,429	$5,545.7	$713.1	$181.6	$337.5	$4,313.6
Year 5 (2013)	1,406,987	$6,118.8	$750.6	$201.4	$403.1	$4,763.7

Table 8: Total NYS and Federal Share of Costs with Maximum and Minimum Federal Match, Year 5.

	Total New Enrollees	Total Government Cost (millions)	Government Costs Assuming Maximum Federal Share*		Government Costs Assuming Minimum Federal Share*	
			NY Cost	Federal Cost	NY Cost	Federal Cost
Adults	1,340,359	$4,670.16	$2,882.49	$1,797.67	$4,670.16	$0
Children	66,628	$93.54	$32.74	$60.80	$93.54	$0
TOTAL	**1,406,987**	**$4,763.70**	**$2,915.23**	**$1,848.46**	**$4,763.70**	**$0**

*Maximum federal share model assumes federal financial participation for enrollees up to 400 percent of FPL.

WHY CORNERSTONE MAKES SENSE FOR NEW YORK

"I like the sliding scale and the cap of 8.7 percent [of family income]. Health care can currently be a very large portion of a person's income. People are being laid off daily and they need a safety net to get them health care coverage. The cost for preventive care is worth it. It's much cheaper in the long run."

- Voter from Rochester, NY

Cornerstone offers a practical, achievable, and cost-effective health coverage option for New York. By leveraging the availability of federal matching funds, New York State could bear as little as $2.9 billion of the total program costs associated with Cornerstone in the fifth year following implementation of the program. With full federal matching funds, New York could finance this program with the existing Health Care Reform Act (HCRA) pools, insurance assessments, or other moderate taxes.[53]

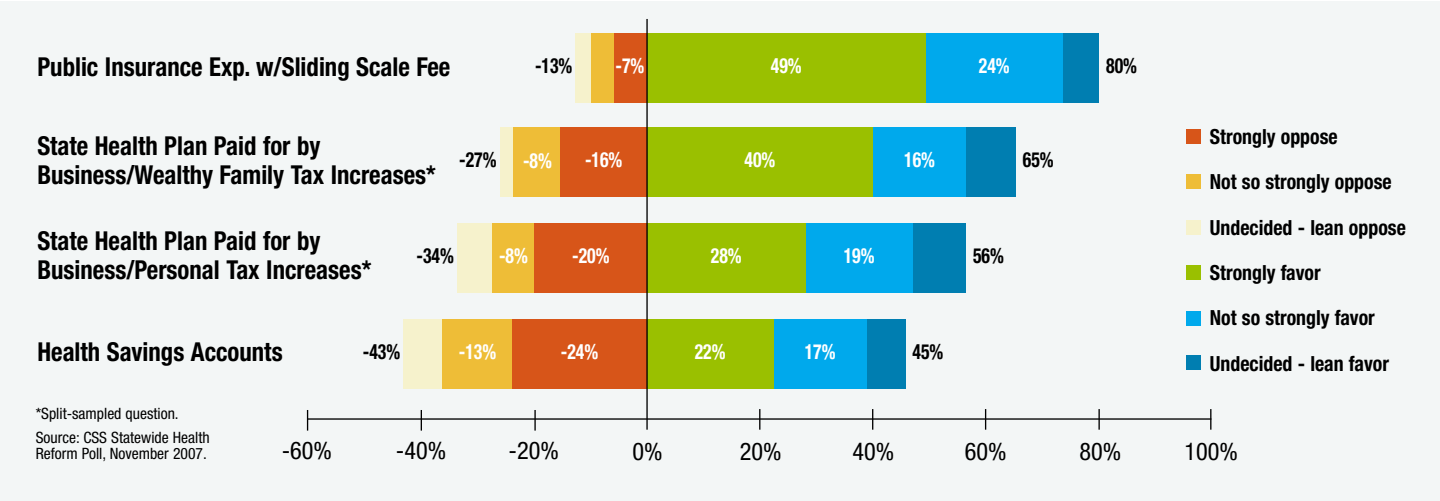
Even without matching funds, independent experts agree that Cornerstone would cover more people for less money than any other comprehensive health reform proposal currently being reviewed by the State.[54] Due to the ability to harness the full purchasing power of the State and affordable family and employer contributions to premium costs, Cornerstone represents a highly cost-effective strategy for addressing the needs of our State's uninsured.

As New York embarks on comprehensive health reform, there are important reasons to explore our main strength in health care—our strong public insurance programs. Our CHP program was the first established children's health insurance program in the nation and led to a national solution to the problem of high rates of uninsurance among low-income children across the country—the federal SCHIP program. Our network of public programs, including CHP, FHP, the Prenatal Care Assistance Program (PCAP), and Medicaid, serve as an important foundation for a health reform solution.

In fact, New Yorkers already show strong support our public insurance programs. Our research shows that 73 percent of New Yorkers support expanding government health insurance like CHP and FHP to cover more of the uninsured, even if it means raising taxes.[55] This support even holds when we use the somewhat stigmatized term "Medicaid." We also asked New Yorkers to rank their support among five different health reform options currently under debate. We found that across every region and income level, New Yorkers overwhelmingly preferred a public insurance expansion with sliding-scale fees over a State health plan paid for by taxes on businesses and wealthy individuals, a State plan paid for by taxes on businesses and individuals without regard to income, and so-called "consumer-directed" health savings accounts (see Figure 9).

Cornerstone echoes both what New Yorkers need and what they have stated that they want. It puts forth an achievable plan for making affordable, comprehensive coverage immediately available to every New Yorker.

Figure 9: New Yorkers' degree of support for different health reforms.



*Split-sampled question.

Source: CSS Statewide Health Reform Poll, November 2007.

Appendices

Appendix A: Cornerstone Enrollment Projections

The total estimated uninsured, ESI, and Direct Pay populations who are expected to transition into coverage will do so over the first five years following implementation. The rate of enrollment was derived from New York's experience with the current FHP program.[1] The entire Healthy NY population is expected to take up coverage under Cornerstone immediately in Year 1, as a result of legislation merging Healthy NY with the Cornerstone program. Based on a review of the yearly enrollment growth in the current FHP program, CSS projects the baseline five-year take-up curve depicted in Table 1.

Table 2, below, outlines the projected accumulative enrollment by population group for the first five years of program implementation.

[1] Data was drawn from the 2002–2006 year-end Medicaid Managed Care Operating Reports (MMCOR), as provided by the New York State Department of Health. Note that Gorman Actuarials estimated the take-up as 3 percent for Direct Pay in Year 5, based on a 98 percent total take-up. However, the difference in enrollment and resulting premium costs is negligible.

Table 1: Five-year take-up projections

Five-Year Take-up Curve	
Year	Take-up as a percent of total projected enrollment
Year 1 (2009)	25%
Year 2 (2010)	35%
Year 3 (2011)	25%
Year 4 (2012)	10%
Year 5 (2013)	5%

Table 2: Total Projected Cornerstone Enrollment by Year and Prior Coverage

Five Year Take-Up Total Projected Accumulative New Enrollment by Year and Prior Coverage					
Year	Uninsured	ESI	Direct-Pay	Healthy NY	Total
Year 1 (2009)	229,464	76,882	18,544	101,702	426,592
Year 2 (2010)	550,713	182,226	44,506	101,702	879,147
Year 3 (2011)	780,177	259,108	63,050	101,702	1,204,037
Year 4 (2012)	871,962	293,298	70,467	101,702	1,337,429
Year 5 (2013)	917,855	313,254	74,176	101,702	1,406,987
Total	**917,855**	**313,254**	**74,176**	**101,702**	**1,406,987**

Appendix B: Overview of Methodology Underlying Cornerstone Premiums

CSS, working with Manatt Health Solutions, developed enrollment assumptions for the expanded CHP and FHP programs under Cornerstone. Actuarial support was provided by Milliman Inc. in developing overall medical and administrative costs for this newly enrolled population. In addition to these projections, CSS worked with Gorman Actuarial, LLC to perform further analyses on member and cost projections specifically highlighting the impact of risk selection on the expanded population. The resulting projected premium costs reflect selection effects for all new enrollees, pent-up demand effects for the current uninsured, medical cost inflation, and various other factors which may impact enrollment and claims costs under the Cornerstone for Coverage proposal. These coverage costs were used to develop cost estimates for the Cornerstone program.

Adult Premium Development

Since selection and take-up varies significantly by newly-eligible populations, an analysis was produced for four major population groupings. These four populations are: (1) the current Uninsured, (2) the Direct Pay population, (3) the Individuals and Sole Proprietors currently enrolled in the Healthy New York Population, and (4) those currently covered under employer-sponsored insurance (ESI). The resulting FHP premiums utilized in modeling the costs under Cornerstone reflect a blended average of the projected premiums for each of these groups, weighted to reflect the projected enrollment levels for each under the proposal (see Table 3).

Child Premium Development

Over the past six years, New York has experienced marginal growth in average CHP premiums of 1.4% per year. As such these premiums were trended forward by this amount in order to project the CHP premiums under Cornerstone. Healthy NY child premium costs were derived by Gorman Actuarial. Based on these premium levels, a blended premium was developed for new child enrollees (see Table 4).

Table 3: Projected Premium Cost by Current Enrollment Group and Blended Total Premium

	Overall Projected Premium Cost by Component Groups - Adults				
	Year 1	Year 2	Year 3	Year 4	Year 5
Uninsured	$329.86	$342.90	$355.93	$370.84	$389.38
Direct Pay	$443.18	$522.77	$612.82	$690.65	$725.18
Healthy New York	$295.19	$309.95	$325.45	$341.72	$358.81
ESI	$288.42	$302.84	$317.99	$333.89	$350.58
Overall	**$320.11**	**$340.76**	**$359.77**	**$378.87**	**$397.56**

Table 4: Projected Premium Cost by Current Enrollment Group and Blended Total Premium

	Overall Projected Premium Cost by Component Groups - Children				
	Year 1	Year 2	Year 3	Year 4	Year 5
Projected CHP Premium	$127.17	$128.95	$130.76	$132.59	$134.45
Projected HNY Premium	$177.12	$185.97	$195.26	$205.03	$215.28
Overall	**$151.01**	**$153.01**	**$152.74**	**$155.50**	**$159.13**

Appendix C: Overview of Cornerstone Cost-Sharing and Program Cost Offsets

The following reflects an overview of cost-sharing and program offsets taken into consideration when calculating overall Cornerstone program costs:

1. Individual and Family Cost-Sharing: Family cost-sharing was calculated by applying the Cornerstone enrollee premium amounts to the projected new enrollees by income level. CSS also accounted for the potential impact of larger families paying less than the sum of the individual co-premiums due to the family co-premium maximum. The total family co-premium offsets were adjusted downward to account for savings to larger families (and corresponding additional governmental cost). Family maximum co-premiums amount to an impact of $33 million on the total individual and family offset of $754 million, resulting in a net offset of $721 million.

2. Employer Cost-Sharing: Only a small number of the projected enrollee population is expected to enroll under the employer buy-in option. Due to the unavailability of adequate data to estimate a precise level of take-up under the employer buy-in, CSS assumed that 5 percent of the enrollees projected will enroll through this mechanism. This enrollment was distributed by family income in equal distribution to the projected new enrollee population, yielding a total estimated employer cost-sharing offset of $201 million.

3. Offset for Savings to Emergency Medicaid: In 2006, New York State spent $547.4 million on emergency care for undocumented immigrants through the Emergency Medicaid program. Extending eligibility for the undocumented would negate a portion of this cost, yielding a cost-savings offset to the Medicaid program associated with this expansion. Assuming that the undocumented would take up public coverage under Cornerstone at roughly the same rate as the population overall (60 percent), total expenditures under Emergency Medicaid are projected to be reduced by 60 percent ($328.4 million) at full implementation of the proposed expansion. Funding for Emergency Medicaid is federally matched at a rate of 50 percent, so these savings are allocated to State and Federal sources accordingly. In the case of no Federal match for the Cornerstone program, it is assumed that the State would at minimum retain all savings to Emergency Medicaid, rather than assuming cost shifting from the Federal government to the State due to Emergency Medicaid savings.

4. Offset for Savings to Healthy New York: As a result of the transition of the individual and sole proprietor programs in Healthy New York, the State will realize significant cost savings as a result of eliminating stop-loss reinsurance payments to Healthy NY plans for these enrollees. According to the 2007 Healthy New York Annual Report, in 2006 State stop-loss expenditures for these two groups totaled nearly $75 million.

Endnotes

[1] Insurance premium increase data from U.S. Department of Health and Human Services, "The Health Care Status Quo: Why New York Needs Health Reform," available at: http://www.healthreform.gov/reports/statehealthreform/newyork.html, n. 3, citing The Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1. Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D. Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at: http://www.cms.hhs.gov/nationalhealthexpenddata.

[2] Families USA, "Costly Coverage: Premiums Outpace Paychecks in New York," September 2009.

[3] Families USA & The Lewin Group, "Too Great a Burden: Americans Face Rising Health Care Costs," April 2009.

[4] Kaiser State Health Facts, available at: www.statehealthfacts.org.

[5] CSS Analysis of 2006–2008 Current Population Survey (CPS), Annual Social and Economic Supplement (ASEC), U.S. Bureau of the Census.

[6] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," August 2007.

[7] Families USA, *supra* n. 2.

[8] CSS, *The Unheard Third Survey,* 2002–2009, available at: www.cssny.org.

[9] CSS, "Findings from a Statewide Poll on Health Reform in New York," February 2008, available at: http://www.cssny.org/userimages/downloads/Cornerstone_for_Coverage_Statewide_Polling_Data.pdf ("CSS Statewide Health Reform Poll"). The margin of error for the full survey is +/- 2.5 percent. The margin of error for each region is +/- 4.9 percent.

[10] Families USA, "Americans at Risk: One in Three Uninsured," March 2009 (data from New York State-specific brief).

[11] For the purposes of this paper, "low-income" is defined as below 200 percent of the FPL; CSS Analysis of U.S. Bureau of the Census, *supra* n.5.

[12] CSS Analysis of U.S. Bureau of the Census, *supra* n.5.

[13] Schoen, C., S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, Volume 27, Number 4 (2008): pp w298-w309; *see also,* Families USA, "Too Great a Burden," *supra* n. 3.

[14] Families USA, "Too Great a Burden," *supra* n. 3.

[15] Institute of Medicine, "Care Without Coverage: Too Little, Too Late," May 2002.

[16] Collins, S. R., J. L. Kriss, M. M. Doty and S. D. Rustgi. "Losing Ground: How The Loss of Adequate Health Insurance Is Burdening Working Families," The Commonwealth Fund, August 2008.

[17] CSS Statewide Health Reform Poll, August 2009, available at: www.cssny.org. CSS polled 1,003 New Yorkers statewide. The margin of error for the full survey is +/- 3.5%.

[18] Ku, L., and V. Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget Policy and Priorities, July 7, 2005; RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Health Reform Debate," 2006; B. Stuart & C. Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs,* Volume 18, Number 2 (1999): pp 201-212.

[19] Howitt, K., "When Coverage Fails: Causes and Remedies for Inadequate Health Insurance," Community Catalyst, April 2009. http://works.bepress.com/cgi/viewcontent.cgi?article=1001&context=christopher_robertson; S. Rubenstein, "Facing a Choice Between Home and Health Care: Housing Rout Cuts Off Source of Funds to Pay Medical Bills; Chemo, and Then Foreclosure," *The Wall Street Journal,* Nov. 25, 2008.

[20] Doty, M., J. Edwards, and A. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills," The Commonwealth Fund, August 2005.

[21] Himmelstein, D., E. Warren, D. Thorne, and S. Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine,* Volume 122, Number 8 (2009): pp 741-746.

[22] Robertson, C., R. Egelhof, and M. Hoke, "Get Sick, Get Out: the Medical Causes of Home Mortgage Foreclosures," *Health Matrix: Journal of Law-Medicine,* Volume 18, Number 65, (2008): pp 65-105.

[23] Affordable health coverage must include monthly premiums *and* out of pocket co-payments that are reasonable and proportionate to the household budget. Since low-income families have little or extra income available to pay for health care (as compared to middle- and upper-income families, who usually have slightly more flexibility in their budgets), cost-sharing should be *progressive,* which means it should be lower for lower-income families and higher for moderate- and upper-income families.

[24] CSS Analysis of New York State Department of Insurance data, "Premium Rates for Standard Individual Health Plans—April 2008," available on line at: http://www.ins.state.ny.us/hmorates/pdf/hmo_rates_full.pdf.

[25] United Hospital Fund, "Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools," 2008.

[26] New York State Department of Insurance, "2008 Annual Report on Healthy NY," January 2009 (prepared by Navigant Consulting, Inc.).

[27] United Hospital Fund, "Health Insurance Coverage in New York, 2006-2007," June 2009.

[28] CSS conducted 258 qualitative interviews with individual New Yorkers from more than eight regions and communities throughout New York State: New York City, Kingston, Poughkeepsie, Albany, a number of communities on Long Island, Binghamton, Buffalo, and Rochester. Household affordability surveys were collected in six locations in New York City, the rest of the surveys were collected either by door-to-door canvassing, solicitations at outreach centers, health clinics, or by mail.

[29] Data from the 2004, 2005, and 2006 Medical Expenditure Panel Survey, Household Component (MEPS-HC), trended forward to 2009. The Northeast census region includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. CSS, "Findings from MEPS-HC on Offers and Take-Up of Employer-Sponsored Insurance and Premium Contributions by Federal Poverty Level," unpublished, October 2007 (updated October 2009).

[30] *Id.* These findings are consistent with a report prepared by the Lewin Group for Families USA, which estimated that in 2008, 19.9 percent of New Yorkers spent more than 10 percent of their pre-tax income on health care costs and 5.7 percent spent more than 25 percent. This includes people with and without insurance. Source: Families USA, "Too Great a Burden: America's Families at Risk," December 2007.

[31] CSS Statewide Health Reform Poll, *supra* n. 9.

[32] *Id.*

[33] CSS Statewide Health Reform Poll 2009, *supra* n. 17.

[34] CSS also tested a series of price points asking respondents to consider their own income or their families' income. We found that support remained strong for these pricing points for individuals and families up to 400 percent of FPL, but that support dropped for families above 400 percent of FPL. More than half of residents below 200 percent of FPL say that they are extremely willing to pay either $18 per month for a single or $45 per month for a family for health insurance (71 percent were either very willing or extremely willing to do so). Three in four (75 percent) of single people were very or extremely willing to pay $18 per month at incomes below 200 percent of FPL; $30 per month at incomes between 200–400 percent of FPL and $70 per month at incomes above 400 percent of FPL for health insurance coverage. Support for the price points held for families, with the exception of families over 400 percent of FPL who expressed skepticism at being asked to pay $350 per month for family coverage (24 percent not at all willing, 52 percent somewhat willing or less). CSS Statewide Health Reform Poll, *supra* n. 9.

[35] Currently, immigration status is not considered when determining eligibility for CHP, but is considered when determining eligibility for FHP or Medicaid. Adult citizens and lawful immigrants (including those considered Permanently Residing Under Color of Law (PRUCOLs)) are eligible for FHP or Medicaid. Many of New York State's uninsured adults are immigrants, some of whom are low-income and face significant barriers to obtaining health insurance coverage. Including immigrants should help bring down the costs of this program for all New Yorkers by building a larger pool and reducing the need to support uncompensated care costs.

[36] For the purposes of this analysis, CSS considered the lowest family income level for each income group in order to yield the maximum possible percentage of gross income a co-premium could represent.

[37] CSS, *supra* n. 29.

[38] N.Y. Soc. Servs. L. §369-ff.

[39] At the lowest employee income levels, employers would split the monthly premium subsidy with the state at a ratio of 70/30, with the employer paying the larger amount. As the employee goes higher on the income scale, thus qualifying for less of a subsidy and potentially having to pay more of the total premium cost on their own, the state's share gradually decreases until it reaches $0, at which point the employer's minimum required share will begin to decrease. Eventually, above 600 percent of FPL the employee could pick up the full cost of the premium, and both the state and the employer would pay nothing (see Table 4).

[40] There are other barriers that discourage employees to drop employer-sponsored coverage in favor of public coverage. Despite streamlining efforts, there are still

significant administrative burdens for those seeking to enroll in public coverage, while enrollment and maintenance of coverage through an employer is usually relatively seamless. In addition, regardless of the benefits offered, there remains some amount of stigma surrounding the receipt of public benefits, including public health insurance. For those who have access to adequate insurance through their employer, this stigma may dissuade them from transitioning to public coverage.

[41] See N.Y. Pub. Health. L. § 2511; N.Y. Soc. Servs. L. § 369-ee(2)(a)(iv)(A); 11 NYCRR § 360.5(d).

[42] CSS Analysis of U.S. Bureau of the Census, *supra* n. 5

[43] Uninsurance among populations currently eligible for subsidized health insurance through CHP, FHP, and Medicaid has been a chronic problem in New York, as in other states. Currently, roughly 40 percent of uninsured New Yorkers are eligible for subsidized coverage under CHP, FHP, or Medicaid, but are not enrolled. (See, e.g., D. Holahan, A. Cook, and D. Miller, "Health Insurance Coverage in New York, 2004–2005," United Hospital Fund, September, 2007.) While enrollment of this population is an important component of universal coverage, it is not the focus of this proposal. Thus, the currently eligible uninsured are not included in the number or associated costs of newly covered individuals.

[44] Data on newly eligible uninsured adults was derived from a 2005–2007 blend of data from the CPS ASEC, weighted to 2007 total population and adjusted to account for the undercounting of undocumented immigrants. Those currently eligible for coverage under FHP or Medicaid are not included in this estimate.

[45] In developing this take-up function, Gorman referred to papers written by Ku/Coughlin and Gruber (See: L. Ku and T. A. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry,* Volume 36, Number 4 (2000): pp 471-490; J. Gruber, "Tax Policy for Health Insurance," National Bureau of Economic Research, Working Paper 10977, December 2004.) In addition, Gorman engaged in direct discussions with Dr. John Gruber to clarify his modeling techniques. However, the final model was not reviewed by Dr. Gruber, and Gorman Actuarial takes full responsibility for the resulting analysis.

[46] Based on data provided by the New York State Department of Insurance.

[47] Given that the premiums under the Cornerstone proposal—even at the full premium level—are significantly lower than those on the Direct Pay market, we did not believe that it was necessary to stratify the Direct Pay population by income level for the purposes of this analysis.

[48] See NYS Department of Insurance, "2007 Annual Report on Healthy NY," prepared by EP & P Consulting (January 2008). Of 145,000 Healthy NY enrollees, 16 percent were sole proprietors and 53 percent were individuals. Based on data from the same report on dependents and children of Health NY enrollees, we estimate that only 80 percent, or 81,362, of the individual and sole proprietor enrollees are adults.

[49] This programmatic change would require legislative authority.

[50] Currently, many employers contribute a significant portion towards their employee's health insurance premium. Also, the enrollment process for ESI is simple and poses fewer barriers for enrollment than public coverage. Many employers also offer comprehensive plan designs that may also contribute to an individual's decision to switch insurance. These factors provide little incentive for an employee to switch coverage. Finally, the state of Massachusetts has currently experienced very little crowd-out through their health reform. See S. Long, "On the Road to Universal Coverage: Impacts of Reform In Massachusetts at One Year," *Health Affairs* Web Exclusive (June 3, 2008): pp w270-w284; J. R. Gabel, H. Whitmore, and J. Pickreign, "Report from Massachusetts: Employers Largely Support Health Care Reform, and Few Signs of Crowd-Out Appear," *Health Affairs* Web Exclusive, Volume 27, Number 1 (2008): pp w13-w23.

[51] The population above 600 percent FPL is not reflected in this cost analysis, as they will pay the full premium cost and thus are cost-neutral to the state and federal payers.

[52] CSS calculated the following three cost offsets: (1) projected cost-sharing by families and employers; (2) Emergency Medicaid Savings; and (3) Healthy NY savings.

[53] See Presentation by Elisabeth R. Benjamin at the Rockefeller Institute of Government Forum on Ideas for Generating and Sustaining Finance for Health Coverage Initiatives in New York State, December 5, 2008, available at: http://www.rockinst.org/pdf/health_care/2008-12-05-ideas_for_generating_and_sustaining_financing.pdf; *see also,* C. Burke and K. Fox, "State Financing for Health Coverage Initiatives: Observations and Options," Rockefeller Institute of Government, June 2009.

[54] Glied, S., N. Tilipman, and O. Carrasquillo, "Analysis of Five Health Insurance Options for New York State," New York State Health Foundation, January 2009.

[55] CSS Statewide Health Reform Poll, *supra* n. 9.

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