



American Cancer Society ☞ Children's Defense Fund/New York ☞ Center for Working Families  
Community Service Society of New York ☞ Metro New York Health Care for All Campaign  
New Yorkers for Accessible Health Coverage ☞ New York Immigration Coalition  
Public Policy and Education Fund of New York/Citizen Action of New York

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**HCFANY Summary, Analysis, and Recommendations  
Of the Urban Institute's July 2009  
Analysis of New York Health Reform Options**

On July 17, 2009, the New York State Departments of Insurance and Health issued a report to the Governor Paterson on the Partnership for Coverage Initiative on the Release of the Urban Institute report. This document first briefly summarizes the contents of the Urban Institute's report; second identifies areas of concerns which HCFANY urges the State to address, and third makes recommendations about what next steps the State should undertake.

While the report is specific to proposals advanced for expansion in New York, it is highly relevant to the national health care reform debate. One of its most important findings is that a strong public plan option will save significant costs in an expansion. It projects savings of 10% of premiums in the public plan as compared to a system based solely on private plans, and a 5% premium reduction in the private plans themselves which must compete with the public plan. Indeed, so powerful are the efficiencies of public coverage that the report projects the overall least costly way to make coverage universal would be through replacing all private coverage with a single public insurer.

The report also highlights just how necessary a generous premium subsidy scheme will be to the success of any system based on the private purchase of insurance. It models two different subsidy schedules, but concentrates principally on modeling a less generous system requiring families to spend up to 12% of income on premiums alone. An analysis of that subsidy system shows that in New York a family facing the resulting high levels of premium, together with other typical fixed expenses such as rent, child care and food, would face a substantial deficit in its family budget even before allowing for some level of "discretionary" spending. A mandate to buy coverage at those premium levels would work substantial hardship on them. The report thus demonstrates the need for a more generous subsidy schedule, such as the second subsidy schedule described in the report. We are pleased that based upon this recognition the State has indicated that it will ask the Urban Institute for further modeling using the more generous schedule.

***I. Brief Summary***

The Urban Institute report analyzes four proposals: (1) a Public-Private Partnership; (2) Public Health Insurance for All (a state single-payer entity); (3) New York Health Plus (Assembly



Member Gottfried's proposal); and (4) the Freedom Plan (a free market approach). The Urban Institute (UI) spends the bulk of its report focusing on the modeling of 18 different variations of the Public-Private Partnership. It briefly describes its modeling of the three other alternatives.

### *Public Private Partnership*

The 18 different models use a “building block” approach to incrementally build upon each other. These steps can be categorized into five primary steps of reform: (1) public insurance expansion; (2) individual and small group market merger; (3) the establishment of a purchasing pool with subsidies; (4) the implementation of individual and/or employer mandates; and (5) the establishment of a public plan. These five steps are approached linearly, with one model from each earlier step serving as the basis upon which to add the next step (e.g. the first group, a modest public expansion, was in all the subsequent models).

According to the UI report, the results for the major steps under the building block model are as follows.

- **Expanding Family Health Plus (FHP) to 200% of the Federal Poverty Level (FPL) (Model 1-2).**

Under this model, FHP and Child Health Plus (CHP) enrollment would increase by 775,000, 260,000 people would drop their employer-based coverage, and 94% of New Yorkers would be eligible for public insurance or have other coverage. The total government cost would be \$2.3 billion, or \$4,392 per newly insured.

- **Market Merger with the FHP expansion to 200% of FPL (Model 1-3).**

The individual direct-pay and small group markets would be merged and FHP would be expanded to 200% of FPL. Under this model, public insurance would cover 850,000 people, 440,000 people would drop employer-based coverage, and 200,000 people would enroll in the direct-pay market, and 94% of the population would be eligible for public insurance or have other coverage. This model would cost the government \$2.5 billion, or \$4,089 per newly insured person.

- **Establish a Purchasing Pool (exchange), Market Merger, and FHP Expansion to 200% of FPL (Model 1-8).**

Under this proposal, the State establishes a purchasing pool, with modest subsidies under “Schedule A,” for insurance costs that people voluntarily purchase. The model assumes that the market has been merged and FHP has been expanded to 200% of FPL.

- Schedule A provides subsidies for people who spend more than: 6% of gross family income (GFI) for people at 200%-249% of FPL; 8% of GFI for people between 250-299% FPL; 10% GFI for people between 300-349% of FPL; and 12% GFI for people between 350-399% FPL. At 400% of FPL, people who want insurance would have to pay the full premium of \$12,764 (which is 14.5% GFI for a family of four or 17% GFI for a family of three).

Under this model, 825,000 gain coverage altogether: public insurance enrollment increases by 924,000; employer-based coverage declines by 600,000; and the individual market increases by 500,000, resulting in 95% of people covered. The government cost would be \$4.6 billion, or \$5,612 per newly insured person.



- Schedule B which provides an affordable sliding fee schedule building off the CHP schedule, capping at 4% for a family at 400% of FPL and 6% for a family of 600% of FPL, was also modeled under this scenario (Model 1-9 and Model 1-10). Schedule B was not modeled again.<sup>1</sup>
  - ✓ Under Schedule B to 400% (Model 1-9), 915,000 people would gain coverage: 980,000 people would have public insurance; the direct pay market would increase by 812,000; and employer based coverage would decrease by 885,000, resulting in 95.8% coverage. The government cost would be \$7.4 billion, or \$8,066 per newly insured person.
  - ✓ Under Schedule B to 600% of FPL (Model 1-10), 982,000 thousand New Yorkers would gain coverage: 983,000 would have public insurance; employer-based coverage would decrease by 987,000; direct pay coverage would increase by 986,000, resulting in 96.2% coverage. The government cost would be \$8.1 billion, or \$8,283 per newly insured person.
- **Mandate Employers to Pay or Play, Purchasing Pool with Schedule A, Market Merger and FHP up 200% of FPL (Model 1-13).**

Under this model, employers with more than 10 employees would either have to provide coverage or pay an assessment. A total of 876,000 would gain coverage: 909,000 through public insurance; employer-coverage would decline by 622,000; and the direct pay market would increase by 589,000. The government would be \$4.5 billion (after employer assessments), \$5,094/insured. 95.5% of people would be either eligible or have coverage.
- **Individual Mandate, Mandate Employers to Pay or Play, Purchasing Pool with Schedule A, Market Merger and FHP up 200% of FPL (Model 1-17).**

Under this model, individuals would be required to buy insurance under Schedule A. It also includes the prior reforms listed in the earlier models. Under the Schedule A mandate, there is no waiver for hardship for people under 400% of FPL who cannot afford to spend 6-12% of their GFI or for people above 400% to spend even more (as much as 17%) of their GFI on insurance. Under this model, 100% of the State would be insured, and approximately 2.7 million gain coverage: public insurance coverage would increase by 1.9 million; employer-coverage would decline by 168,000; and direct-pay coverage would increase by 981,000. The government cost would be \$7.2 billion (after employer assessments), for a cost of \$2,663 per newly insured person.
- **Public Option, Individual Mandate, Mandate Employers to Pay or Play, Purchasing Pool with Schedule A, Market Merger and FHP up 200% of FPL (Model 1-18).**

Under this model, the State would offer a public option with similar benefits as those insurers in the purchasing pool. The public plan would operate like fee-for-service Medicare, paying providers somewhere between the current Medicare and private pay rates. The same coverage rates would occur in this plan as were achieved in Model 1-17, above, but the government costs would be slightly smaller, at \$7.1 billion (after employer assessments), \$2,128 per newly insured person. The report claims that larger savings will occur over time, asserting that 10% savings

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<sup>1</sup> The number of “crowd-out” (or substitution of employer-sponsored coverage for publicly-subsidized coverage) enrollees found by the Urban Institute is more than double the levels of crowd-out determined by Columbia University (300,000-400,000) or the Community Service Society (385,000).



will be achieved by year 10 of post reform in the public plan and an additional 5% savings will be achieved in private plans, because of the need to compete with the public option.

### *Single-Payer Proposal (Model 2-1).*

The single-payer model would automatically enroll most New York residents into a public health insurance plan. However, people on public insurance (Medicaid, FHP, CHP) would stay in these programs in order to keep receiving the federal match. Spending for these enrollees would increase by 18% because of the higher reimbursement rates required to pay providers. The administrative costs are assumed to be 5%.

The State would achieve 100% coverage. Total government spending would be \$57.7 billion. \$33.3 billion in employer spending would be eliminated and \$22 billion in individual savings would incur (the report emphasizes that \$11 billion of these savings would go to those above 400% of FPL). The report states that aggregate change in health system would be \$2.4 billion (smaller than any other proposal).<sup>2</sup>

### *New York Health Plus (Model 3-1)*

Under New York Health Plus, all residents would be automatically enrolled in a FHP-like product. There would also be a fee-for-service (FFS) public plan option similar to Medicare for those residents who opt into it. Employers would pay a 10% payroll tax. Employers could continue to provide coverage at their option (paying a smaller tax). This model would also increase public insurance spending by 18%. The report concludes that the proposal would only achieve 3% in administrative savings because providers would be allowed to collectively bargain.

The State would achieve 100% coverage. Employer-based coverage would decline by 6.2 million (-60%); FHP coverage would increase by 7.4 million; and an additional 1.7 million would be enrolled in Medicaid or Child Health Plus. (No estimate is provided for how many will go into FFS Medicare-like program). The total government costs would increase by \$47.5 billion: the employer assessment would raise \$13.6 billion; so the net government costs would be \$33.9 billion. Employers would save \$9.9 billion, individuals save \$17.9 billion. The aggregate change in health spending would be \$6.1 billion.

## ***II. HCFANY Analysis Concerns***

HCFANY has a number of concerns, described in detail below, about the report involving: the role of public coverage; the affordability standard adopted for the majority of the UI modeling process; crowd out assumptions and its impact on costs; and the need for greater depth of analysis to understand the dynamics of both the single-payer and New York Health Plus options. While the

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<sup>2</sup> Single-payer advocates have identified that under the Urban Institute's methodology, the State would save the State \$20 billion in health care spending by 2019. Press Release of Single Payer NY and Hunger Action Network of New York State, July 28, 2009.



concerns below constitute HCFANY's major concerns, we have additional questions regarding about the Urban Institute's assumptions and conclusions.<sup>3</sup>

1. *Concerns about the Role of Existing Public Coverage in New York.*

HCFANY is concerned that the UI report fails to adequately model further expansion of existing public insurance programs in New York as part of the Public-Private partnership options. The report does not model the expansion of Family Health Plus above 200% of FPL and develops a different "Medicare-like" public option. In addition, it does not model a sliding-scale buy-in to Family Health Plus, along the lines of our existing CHP program. The State of Massachusetts and the United Hospital Fund's proposal both expanded existing programs with subsidies up to 300% of FPL. The Community Service Society's Cornerstone proposal similarly built upon existing public programs with subsidies up to 600% of FPL. These options have the possibility of bringing in additional federal funds and offering a comprehensive product at somewhat lower rates. Building upon the existing program has logical benefits, such as shorter start-up delays and current infrastructure and capacity advantages, which could be relatively quickly built upon.

In response to our concerns, the Departments of Health and Insurance explained that Urban Institute recommended using a public fee for service (Medicare for All type) plan, rather than a FHP expansion, for people above 200% of poverty because: (a) additional savings could be achieved by eliminating the private insurers running FHP; (b) expansion would be faster if the State did not have to wait for the private FHP plans to expand their provider networks; and (c) they did not believe that the potential of federal matching funds through a FHP expansion would be the only way to bring in a significant federal financing contribution.

As set forth in our recommendations, below, HCFANY believes that the relative advantages of opening FHP on a sliding scale to those above 200% of FPL and creating a separate public fee for service plan for the same population would best be determined by modeling the FHP expansion as well.

2. *Concerns about the Adoption of an Inappropriate Affordability Schedule.*

While the Urban Institute spends the majority of the report modeling the Public-Private Partnership approach, it utilizes an affordability schedule that is both practically and theoretically unworkable, thus making the exercise of limited utility to the policy making process in New York.

First, as a practical matter, the building-block approach is built on unrealistic assumptions about what people can afford to, and will, pay for health care. As the charts below demonstrate, Schedule A, which is relied upon for all but two of the 18 building block models, is untenable for the very New Yorkers it is designed to benefit—those living between 200-400% of FPL.

In order to get coverage (or in some models to comply with the individual mandate), most New Yorkers at these income levels will end up in debt. The tables below demonstrate this reality

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<sup>3</sup> For example, Model 1-5 alludes to the possibility of an enhanced reinsurance system for small groups under the merger, but does not clearly explain whether UI assumes the continued existence of current reinsurance mechanisms for the Direct Pay market and for Healthy NY.



after including only the following few basic expenses of living: taxes, housing, food and child care. These charts do not include other necessary expenses, such as transportation, fuel costs, heat and electricity costs, school supplies, telephone, credit card payments, loans, and other miscellaneous expenses.

**Table 1 – What Urban Institute’s “Schedule A” Means for a Family of Three**

Family of Three – One Adult, Two Children					
	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
Gross Yearly Pay	\$36,620	\$45,775	\$54,930	\$64,085	\$73,240
Taxes	\$6,137	\$9,195	\$12,253	\$15,311	\$18,373
<b>Net pay</b>	<b>\$30,483</b>	<b>\$36,580</b>	<b>\$42,677</b>	<b>\$48,774</b>	<b>\$54,867</b>
Housing Costs	\$14,400	\$14,880	\$14,760	\$15,012	\$17,160
Child Care	\$19,087	\$19,087	\$19,087	\$19,087	\$19,087
Food	\$7,611	\$7,611	\$7,611	\$7,611	\$7,611
Health Costs:					
Schedule A	\$2,197	\$3,662	\$5,493	\$7,690	\$12,400
Maximum OOP	\$3,980	\$3,980	\$3,980	\$3,980	\$3,980
<b>Remainder - annual</b>	<b>(\$16,792)</b>	<b>(\$12,640)</b>	<b>(\$8,254)</b>	<b>(\$4,606)</b>	<b>(\$5,371)</b>
<i>Remainder - monthly</i>	<i>(\$1,399)</i>	<i>(\$1,053)</i>	<i>(\$688)</i>	<i>(\$384)</i>	<i>(\$448)</i>

**Table 2 – What Urban Institute’s “Schedule A” Means for a Family of Four**

Family of Four – Two Adults, Two Children					
	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
Gross Yearly Pay	\$44,100	\$55,125	\$66,150	\$77,175	\$88,200
Taxes	\$7,981	\$11,663	\$15,345	\$19,035	\$22,729
<b>Net pay</b>	<b>\$36,119</b>	<b>\$43,462</b>	<b>\$50,805</b>	<b>\$58,140</b>	<b>\$65,471</b>
Housing Costs	\$14,400	\$14,880	\$14,760	\$15,012	\$17,160
Child Care	\$19,087	\$19,087	\$19,087	\$19,087	\$19,087
Food Costs	\$11,531	\$11,531	\$11,531	\$11,531	\$11,531
Health Costs:					
Schedule A	\$2,646	\$4,410	\$6,615	\$9,261	\$12,400
Maximum OOP	\$3,980	\$3,980	\$3,980	\$3,980	\$3,980
<b>Remainder - annual</b>	<b>(\$15,525)</b>	<b>(\$10,426)</b>	<b>(\$5,168)</b>	<b>(\$731)</b>	\$1,313
<i>Remainder - monthly</i>	<i>(\$1,294)</i>	<i>(\$869)</i>	<i>(\$431)</i>	<i>(\$61)</i>	\$109

**Sources:** Taxes are based on NYC residency with federal withholding exemptions of three for a three person family and four for a four 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. Health Costs are taken from Subsidy Schedule A for maximum percentage of family income an individual or family would pay for premiums for private insurance, and deductible amount for standardized package modeled by Urban Institute. Amount for 400% FPL family is post-reform non-group insurance premium for family. Source: Urban Institute Analysis, HIPSMA 2009.



Moreover, the Urban Institute's affordability caps do not account for the impact of the maximum out of pocket expenses of \$3980 which they assumed under its modeling.<sup>4</sup> When the maximum out-of-pocket expenses are included, a family of three at 200% of FPL will be mandated to spend nearly 17% of their gross family income, not the 6% indicated under Schedule A. The Urban Institute fails to recognize the well-documented, and significant, financial (not to mention physical and psychological) impact that cost-sharing in standard health plans (like those modeled in both the Building Block and Freedom Plan models) has upon patients who are seriously ill or have chronic diseases.<sup>5</sup>

Indeed, it is unclear the extent to which the building block approach would perpetuate and potentially increase the numbers of New Yorkers who are underinsured.<sup>6</sup> To the extent insurance products available in the purchasing pool fail to remedy the inadequacies of some employer-based coverage, Healthy NY, or Medicare, significant coverage gaps and cost-shifting to sicker individuals will continue to be a part of our system. HCFANY believes that the benefit plan which is assumed as the basis for the analysis should be spelled out more explicitly, and the extent to which medical costs may continue to be uncovered should be an explicit part of the analysis.

Second, as a theoretical matter, HCFANY is concerned that the affordability threshold up to 12% of family income (and even higher for families above 400% FPL) as proposed in the Urban Institute report is inconsistent with the leading research on affordability. In her 2007 *Health Affairs* article, upon which Schedule A is based, Linda Blumberg and her colleagues argue that the full cost of employer coverage (12%-15% of family income) is the appropriate affordability threshold, rather than the employee share of employer coverage, costs in the non-group market, or some other level, because employees currently bear the full cost of coverage in the form of lower wages.<sup>7</sup> This long-term macroeconomic theory cannot be applied directly to setting affordability thresholds for the initial stages of a coverage expansion, since it does not reflect wage-based resources available to families to purchase coverage in the short and medium term, nor does it hold equally for workers in different circumstances.<sup>8</sup>

The Blumberg methodology also is out of step with the prevailing researchers in the area of affordability, which have recommended substantially lower affordability thresholds for middle-income families, in the range of 3.4-6.8% (Kenneth Thorpe),<sup>9</sup> 8.5% (Barber and Miller, 2007),<sup>10</sup> or 5-

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<sup>4</sup> Urban Institute, "Final Report: Achieve Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options," July 17, 2009, n.13 at 11.

<sup>5</sup> Georgetown University Health Policy Center & American Cancer Society, "How the FEHBP Blue Cross Blue Shield Standard Option Plan Covers Medical Care for Patients with Serious Chronic Conditions," July 2009, available at: [http://action.acscan.org/site/DocServer/A\\_Benchmark\\_for\\_Coverage.pdf?docID=14361](http://action.acscan.org/site/DocServer/A_Benchmark_for_Coverage.pdf?docID=14361).

<sup>6</sup> Schoen, Cathy, Sara E. Collins, Jennifer L. Kriss, and Michelle M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008:w298-w309.

<sup>7</sup> Blumberg, Linda J, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting A Standard Of Affordability For Health Insurance Coverage," *Health Affairs*, Web Exclusive, 2007.

<sup>8</sup> Sommers, Benjamin D. 2005. "Who Really Pays for Health Insurance? The Incidence of Employer-Provided Health Insurance with Sticky Nominal Wages," *International Journal of Health care finance and Economics*, 5, 85-118; Blumberg, Linda J., 2009, "Who Pays for Employer-Sponsored Health Insurance?" *Health Affairs*, 18(6), 58-61.

<sup>9</sup> Thorpe, Kenneth E. "Overview of Catamount Health." February 23, 2006.

<sup>10</sup> Barber, Christine and Michael Miller, "Affordable Health Care for All: What Does *Affordable* Really Mean?" Community Catalyst, April 2007.



10% of family income.<sup>11</sup> The sole real world experience of any scale is in Massachusetts, where the Connector Authority uses affordability thresholds of 8% of income below 400% FPL, and 10% of income above 400% FPL. In fact, no other studies using percent of family income methodologies approach the 12% threshold.<sup>12</sup>

Significantly, under the Massachusetts model, 20% of uninsured individuals and families are waived out of coverage mandates on affordability grounds. Nowhere in the UI report is there a recognition that inadequate subsidies levels, such as those described in Schedule A, will create significant hardships and ultimately, may require the exemption of hundreds of thousands of New Yorkers.<sup>13</sup>

Finally, as a political matter, both the House Tri-Com and Senate HELP bills incorporate lower affordability elements (e.g. at 200% of FPL and above 400% of FPL) than those used in the Urban Institute report. It appears singularly unhelpful to New York's position in the federal health reform debate to have the State's modelers signaling that New Yorkers would be in a position to afford premiums under as described in Schedule A.

### 3. *Concerns about "Crowd-out" estimates*

The number of "crowd-out" (or substitution of employer-sponsored coverage for publicly-subsidized coverage) enrollees found by the Urban Institute is considerably higher than the numbers found in other modeling of public program expansions by the Community Service Society and Columbia University, for example.<sup>14</sup> It appears one reason for this discrepancy may be the assumption throughout this report that market "merger" would have a crowd-out effect for those who are above 200% of PFL. The report asserts that high needs individuals would turn down job-based coverage for better non-group coverage. This assertion appears to ignore current New York law, which exempts insurers from selling non-group coverage to persons eligible for employer-sponsored coverage.<sup>15</sup> A similar prohibition exists for those applicants to Family Health Plus who are below 200% of FPL and to Child Health Plus.<sup>16</sup> The UI report's inflated "crowd out" estimates

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<sup>11</sup> Schoen, Cathy, Sara E. Collins, Jennifer L. Kriss, and Michelle M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008:w298-w309.

<sup>12</sup> Greater sensitivity to affordability concerns would be helpful in other areas of the analysis as well. The Urban Institute's assertion (at p. 51) that subsidies would have little effect above 400% of FPL in New York because of our existing community rating rules is puzzling indeed. The assertion is based upon the notion that New York does not have great disparities in premiums based on age, and therefore that extremely high premiums are not a problem for higher income individuals. It appears to ignore the absolute high level of premiums in the current non-group market affecting all age groups and even in a merged small group and non-group market.

<sup>13</sup> According to a CSS analysis which applies Massachusetts Model to New York, depending on the level of premium reductions achieved through health reform, somewhere between 383,000 and 516,000 New Yorkers would have to be provided an "affordability waiver" and remain uninsured. CSS Analysis, dated June 16, 2008 provided to the New York State Department of Insurance.

<sup>14</sup> Glied, Sherry, Nicholas Tilipman, Olveen Carrasquillo, "Analysis of Five Health Insurance Options for New York State," New York State Health Foundation, January 2009.

<sup>15</sup> 11 NYCRR § 360.5(d).

<sup>16</sup> The report also assumes large crowd-out levels (260,000 individuals) for those below 200% of FPL which also disregards the existence of anti-crowd out law in the FHP. *See* N.Y. Soc. Servs. L. § 369-ee(2)(a)(iv)(A). Although the report does not indicate what portion of their crowd-out estimates are attributable to people under the age of 19, to the extent children constitute a portion of the UI crowd-out estimates, a similar issue may arise because Child Health Plus program likewise has an anti-crowd out provision. *See* N.Y. Pub. Health L. § 2511.



are significant because they directly increase the State's costs of covering those individuals either under Family Health Plus or through the subsidy program.<sup>17</sup>

#### 4. *Concerns about the Single Payer Proposal (Model 2-1)*

The Urban Institute appears to have devoted comparatively little time to analyzing the single payer model, even though the limited analysis conducted suggests that, as expected, it is the most economical of all the options reviewed. The finding that the single payer model would add \$2.3 billion to total state spending is in conflict with every other study of single payer plans conducted over the last two decades. All of these suggest that a single payer plan would cost no more in total spending than is currently being spent, and most suggest savings on the order of 5%, or about \$4-5 billion for New York State.<sup>18</sup>

The Urban Institute report also asserts that the economies achieved in the single payer plan are the result of using lower Medicare reimbursement rates and of administrative savings, but the study does not model the plan with private or average reimbursement rates. Policy makers cannot determine what portion of the Urban Institute's result is due simply to the assumption of lower reimbursement rates. Because there is so little detail, it is impossible to evaluate the study's results, or determine why its findings differ so much from previous studies.<sup>19</sup>

Finally, HCFANY is concerned that the Urban Institute report appears to find no savings attributed to the simplification of billing systems. In other analyses, these savings amounted to as much as 10% of all spending.<sup>20</sup> The model assumes that Medicaid and Medicare remain as separate systems. But even with three payers, there would certainly be savings from this simplification, and these do not appear to have been included. This omission might explain why the Urban Institute result is at variance with previous studies. However, since there is so little detail given, it is difficult to tell if this is so.

#### 5. *Concerns about the New York Health Plus Model (3-1)*

New York Health Plus is a complex program with a number of parts, but the report does not provide a basis for understanding how the parts would relate to each other, or how many people

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<sup>17</sup> Permitting employed individuals to satisfy state coverage mandates by buying non-group coverage may not be the only way states can, within the limits of ERISA preemption, create pressures for improved employer provided plans. An ERISA waiver under federal health reform or sale of non-group "wrap-around" coverage should also be considered.

<sup>18</sup> The Lewin Group, "Technical Assessment of Health Care Reform Proposals – Proof Report," prepared for the Colorado Blue Ribbon Commission for Health Reform, August 20, 2007. Sheils, John and Randall Haught, "The Health Care for All Californians Act: Cost and Economic Impact Analysis," prepared for Health Care For All Education Fund by the Lewin Group, January 19, 2005. Thorpe, Kenneth, "Impacts of Health Care Reform: Projections of Costs and Savings," National Coalition on Health Care, 2005.

<sup>19</sup> This difficulty is reflected in the report's conclusions comparing the single payer model and the conceptually quite similar New York Health Plus. It estimates that the single payer proposal achieves universality at the lowest cost while New York Health Plus does so at virtually the highest cost. The report attributes much of the difference in cost to the "collective bargaining" permitted to doctors in New York Health Plus, as opposed to the rate setting powers of a single payer on the Medicare model in the single payer system, but does not explain how much of the differential is attributable to these factors, whether other structural features (like the number of payers) are significant, and whether there are policy choices which might change the effects of the negotiating power imbalances identified. (What if the single payer plan allowed collective bargaining by doctors? What if the state took a more vigorous approach to setting reimbursement in New York Health Plus?).

<sup>20</sup> *Id.*; see also, Woolhandler, S., T. Campbell and D. Himmelstein, "Cost of Health Care Administration in the United States and Canada," *The New England Journal of Medicine*, 349:768-75.



would take advantage of each part. In particular, the Urban Institute did not seem to have included the fee-for-service (public plan) option in its analysis or assumed that any significant number of people would take advantage of it. A similarly-structured public option was used to indicate significant savings (at year 10) in Model 1-18 of the Public Private Partnership proposal, which makes this a notable omission.

As noted above, the Urban Institute study does not appear to have considered the impact of the very different structures of financing and service provision in New York Health Plus as compared, especially, with the Public Health Insurance for All plan. This may be a result of the very high level of abstraction that seems to characterize these two sections of the report. Also, the financing assumed to fund the program don't seem adequate for this purpose, so the State is left with additional expenditures but no funds to pay for them.

The Urban Institute report also anticipates capacity issues for the New York Health Plus and Single Payer models (Model 3-1 and 2-1 on page 20), but fails to concede that these same capacity issues also will be prevalent under those Public-Private Partnership models which contemplate an individual mandate (Model 1-11, 1-16, 1-17, 1-18). This would be consistent with the experience in Massachusetts, where such problems were the focus of numerous news reports.

### ***HCFANY Recommendations***

Recommendation #1: The State or Urban Institute should demonstrate how each model would affect typical New Yorker. It should make more explicit what it assumed to be a base line benefit package, and the extent to which the various models would preserve coverage that does not meet that base line package. In HCFANY's comments on the State's modeling instructions to the Urban Institute, we provided a list of typical New Yorkers for which the models should be elaborated upon. For example, how would the following individuals be affected under each of the four models: a family of four at 400% of FPL in Nassau with a child with diabetes; a 32-year old sole proprietor who is HIV+ living in Manhattan; a farming family of two adults (he farms, she works part-time at a Stewart's Shop) and three children in Schoharie County who make \$45,000).<sup>21</sup>

Recommendation #2: The state should model a further expansion of FHP above 200% of FPL on a subsidized buy-in basis to 300-400% of FPL, and on a full-premium basis for those above the subsidized levels. The report should clarify whether expansion includes all adults, whether or not in families.

Recommendation #3: The state should model the effects of a subsidy schedule which goes considerably higher on the income ladder than 300% of FPL according to a reasonable standard of affordability, and should address the subsidies to overall out of pocket medical costs, not just premiums. It could do this by using the Schedule B levels of subsidy, applied to all medical costs, as the standard. In the analyses using Schedule A, it should also model the points at which it would have to grant exemptions from the enrollment mandate and what effect that would have on achieving universality.

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<sup>21</sup> See HCFANY letter to Deborah Bachrach and Troy Oechsner, dated July 18, 2008, which details 10 different scenarios of typical New Yorkers.



Recommendation #4: The modeling of the Public-Private Partnership should be reconsidered assuming that New York’s rules for maintenance of current employer sponsored coverage (as reflected in eligibility for non-group and Family Health Plus coverage) will remain in place.<sup>22</sup>

Recommendation #5: The considerably greater detailed explanation of the factors leading to the cost differentials in the models based on universal public coverage is needed. How much of the cost in these two models is attributable to the dictating of reimbursement rates by one side or the other? How much is attributable to other features of the plans? How much administrative cost does single payer save, when compared with New York Health Plus? Is there something about having a multitude of payers that adds costs? What is the effect of New York Health Plus permitting the continued existence of ESI and giving a tax credit for its maintenance? Without an understanding of how these variables work, policy-makers will not have an adequate basis for going forward.

## ***CONCLUSION***

HCFANY believes that modeling is an important instrument in the fight for affordable, quality health care for all New Yorkers. We offer these comments to help move the process forward and urge the State to consider conducting additional modeling which incorporates these recommendations. In any event, HCFANY stands ready to work with the Governor and the staff at the New York State Departments of Health and Insurance to continue to push for thoughtful and comprehensive State health reform and to support New York’s role in the federal conversation.

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<sup>22</sup> The report appears to rely on the ability of individuals to buy non-group coverage as a means around ERISA – it assumes the State cannot dictate the adequacy of benefit plans to groups because of ERISA preemption, and that it must therefore impose an individual mandate that will cause individuals to pressure their employers to provide the mandated level of benefits or to abandon the group for non-group coverage. While this is an interesting legal strategy, it does appear that alternative strategies, including an ERISA waiver under federal health reform or sale of non-group “wrap-around” coverage to supplement employer plans could also be considered.