HEALTHY NEW YORK:
MAKING INSURANCE MORE AFFORDABLE FOR
LOW-INCOME WORKERS

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ABOUT THE AUTHOR

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EXECUTIVE SUMMARY

Concern for the nearly 3 million people without health insurance who live in New York State prompted the legislature to pass the Health Care Reform Act of 2000 (HCRA 2000). The initiative, which consists of Healthy New York and Family Health Plus, is intended to increase the number of New Yorkers with health care coverage by making it more affordable. About one million people are eligible for coverage under the new law.

Healthy New York, which began enrolling people in January 2001, has three parts: one for businesses with 50 or fewer employees, one for low-income sole proprietors, and one for low-income uninsured workers. To be eligible, a small business must have at least 30 percent of its employees earning no more than $30,000 and at least one of these employees must enroll in the plan. At least half of the eligible employees in the small firm must participate, and the firm cannot have provided health insurance to its employees in the preceding 12 months. To qualify, sole proprietors and individuals must have household incomes below 250 percent of the poverty level, must not be eligible for Medicare or private insurance, and must not have had coverage in the preceding 12 months.

All health maintenance organizations (HMOs) in the state must participate in the program; other carriers have the option to participate. By requiring all HMOs to offer the Healthy New York policy, the state is relying on managed care techniques to restrain health care costs. Healthy New York also requires each carrier to community rate the premiums for small firms and individuals/sole proprietors jointly for each of the different policy tiers (single, husband/wife, adult and children, family) for the people it covers. So even if the claims experience for those who enroll through small firms is better than that of individuals or sole proprietors, the people in small firms will be cross-subsidizing individuals because the premiums for everyone covered by the carrier in the same policy tier must be the same.

Three features of Healthy New York were designed to yield lower premiums than those currently available in the individual and small group markets. The first, and most important, design feature is the stop-loss fund created by the state to pay for up to 90 percent of the costs of enrollees with annual claims between $30,000 and $100,000. The state in effect takes on the role of reinsurer, implicitly subsidizing the premium by removing much of the insurers' risk of high-cost claims. This design feature makes the

Healthy New York approach to reducing premiums different from approaches that directly subsidize premiums.

The second premium-lowering feature is a leaner benefits package than currently available in New York's individual market or many small group markets. The package is exempt from state requirements to cover certain services such as mental health care, home health care, chiropractic care, and outpatient treatment of alcoholism and substance abuse.

The third feature designed to lower premiums depends on higher cost-sharing (or copayments) and requires that services be obtained from the network of HMO providers. By shifting some expenses to enrollees and managing care within the HMOs, costs can more easily be contained. To support the plan, the legislature allocated $219 million for Healthy New York over a 30-month period between January 1, 2001 and July 1, 2003 and another $130 million to stabilize the individual market.

Healthy New York's initial premiums, as of February 2001, are indeed lower than premiums in the individual market and for comparable HMO policies in the small group market. Premiums for qualified individuals are mostly 30 to 50 percent less than premiums in the individual market. Premiums for small groups are harder to compare to the small group market overall because the market lacks standardized plans. But for comparable HMO policies, Healthy New York premiums are about 15 percent to 30 percent less than in the small group market. The initial round of premium offerings for Healthy New York therefore suggests that the design features of Healthy New York worked to substantially reduce premiums.

However, premiums still account for more than 5 percent of before-tax income for most individuals and many low-income workers in eligible small firms. As a result, it is not clear that Healthy New York's target beneficiaries will purchase coverage through the program in large numbers. Three options to modify Healthy New York might further reduce premiums and increase enrollment:

- Give direct subsidies to individuals to purchase coverage

- Adjust the reinsurance mechanism, and

- Add a second standardized benefits package, as permitted under HCRA 2000, and plan to add one or two additional packages.

Healthy New York's innovative design provides a new approach to reducing health insurance premiums for lower-income working people. Whether or not the reduced premiums are sufficient to attract large numbers of lower-income people will become clearer in the coming year or two. Modifying the legislation to incorporate the three options described would help ensure greater acceptance of this new opportunity to buy health coverage. In the meantime, policy analysts throughout the country will undoubtedly be interested in Healthy New York's unique approach to reducing premiums.

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INTRODUCTION

One of six New Yorkers—approximately 3 million people—lacks health insurance, prompting the passage of New York's Health Care Reform Act of 2000 (HCRA 2000) in late 1999. Healthy New York and Family Health Plus are the two major insurance expansion initiatives contained in HCRA 2000. Healthy New York is designed specifically for workers who may be ineligible for other state insurance programs. In just one year, the Insurance Department of New York not only drafted all the regulations and administrative processes necessary for implementing Healthy New York, but obtained the cooperation of health maintenance organizations (HMOs) to implement the program. This was an impressive accomplishment, especially since Healthy New York involves a new approach to reducing health insurance premiums for low-income individuals and small firms.

Healthy New York began operations in January 2001, and the first enrollees were covered on February 1, 2001. Unlike earlier New York State programs to help the uninsured or the other programs contained in HCRA 2000, Healthy New York does not involve direct subsidies to small firms or to low-income workers. Instead, it reduces premiums, compared to those in the individual and small group markets, by paying most of the expenses of high-cost people who join the program.[1] If the insurance companies and managed care organizations (the carriers) do not have to pay high claims, premiums can be reduced significantly to allow lower-income people to afford the policies. To pay for the high-cost people who enroll, New York has earmarked funds for reinsurance for the carriers selling Healthy New York. The reinsurance pays up to 90 percent of claims between $30,000 and $100,000 per year for each enrollee. Carriers pay all costs below $30,000 and above $100,000, and 10 percent of the costs between $30,000 and $100,000.

The definitive question is: Will the premium reductions achieved by this reinsurance strategy be enough to attract substantial numbers of uninsured people? The analysis in this paper shows that, in the first year, the reinsurance strategy led to fairly large reductions (30 to 50 percent, and in some instances, 70 percent) in premiums for

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[1] While Healthy New York's approach has not been implemented before, the idea that the state should reinsure high-cost claims was part of the 1990 New York State Department of Health proposal for Universal New York Health Care (UNY-Care). UNY-Care proposed that insurers be granted a stop-loss limit of $25,000 per person per year for inpatient costs, and another $25,000 per person per year for out-of-hospital services. A surcharge on health insurance plan premiums was proposed to fund this "catastrophic" care. See Beauchamp and Rouse (1990).

individuals who do not have access to group insurance—i.e., those who can purchase coverage only in the individual market (what New York calls the "direct-pay" market). Since the small group market does not have standardized policies and many require high cost-sharing, comparisons are difficult, but it appears that Healthy New York premiums are at least 15 to 30 percent below the small group rates.

Unfortunately, though, the Healthy New York premiums for qualified individuals (those with family incomes below 250 percent of the poverty level) still constitute a high percentage (more than 5 percent) of their before-tax income.[2] And for people with incomes below $30,000 who work in small firms, the very modest reductions in premiums means that they pay more than 3 percent of their before-tax income for coverage, even though employers must pay at least half of the Healthy New York premium. Since most of the uninsured are low-income people and therefore quite price sensitive, it is unlikely that the program will result in substantially reducing the number of uninsured. However, Healthy New York is only 11 months old and it is possible that premiums could be reduced further in the next year once the carriers and the state Insurance Department gain claims experience with the program. The program may be modified in the future and changes are even suggested in HCRA 2000.

I. THE NEED FOR HEALTHY NEW YORK

Large Percentage of Uninsured

Nearly 3 million New Yorkers are uninsured, according to the U.S. Bureau of the Census, March 2000 Current Population Survey. The number is widely expected to rise this year in the aftermath of the terrorist attacks on New York City and the economic slowdown that began prior to September 11.

Although many of the uninsured in New York work or have a family member who works, they are still predominantly poor and do not have employer-sponsored health coverage. Two-thirds of the nonelderly uninsured in New York have family incomes below 200 percent of the poverty level (Haslanger et al. 1998)—poverty income was $13,303 for a family of three in 1998 and $16,600 for a family of four. About three-fourths of nonelderly uninsured New Yorkers either work or live in families with at least one working adult (Haslanger et al. 1998). Further, among all working adults in 1999 (8.2 million people in the state), a quarter worked in firms that did not offer health insurance coverage (2.3 million). Of those workers not offered coverage, 43 percent did not buy

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[2] Although most people with incomes below $25,000 or 150 percent of the poverty level pay very little income tax on their earnings, they do pay payroll taxes, which equal about 8 percent of their earnings (and more than 15 percent of earnings if the employer portion of payroll taxes is viewed as paid by the employee—the standard view of economists).

insurance elsewhere and were uninsured (Thorpe and Florence 2000). These one million uninsured workers also account for three-quarters of all uninsured workers, indicating that working for a firm that does not offer insurance coverage is a serious barrier to obtaining coverage (Thorpe and Florence 2000).

Health insurance options for adults also affect coverage for children. Of the 770,000 uninsured children in New York, more than 415,000 had at least one parent working full-time all year in 1996 (Haslanger et al. 1998). More than 275,000 children had family incomes below 200 percent of the poverty level.

Thus, the uninsured in New York lack health insurance largely because an employer does not offer insurance, or because they cannot afford to pay the cost-sharing required by their employer—either for themselves or their dependents.

High Premiums as a Barrier to Coverage
Small firms are more likely not to offer coverage than medium to large ones. In 1996 in New York, 61 percent of workers in firms with one to 24 employees and 73.5 percent of workers in firms with 25 to 99 employees had private health insurance, considerably below the 85 to 87 percent of workers in firms with 500 or more workers. The per capita cost of insurance for small firms is higher, due to higher costs per capita for marketing and processing enrollments and disenrollments. Higher variance in expected costs for small groups compared to large groups also contributes to higher costs. These costs are often referred to as "loading fees." As a percent of benefits paid, loading fees are typically 20 to 30 percent for groups of 11 to 100 people compared to 5 to 8 percent for groups of 1,000 or more (Phelps 1998).

A recent survey funded by the Kaiser Family Foundation and the Health Research and Educational Trust (2000) found that the national average annual premium (employer and employee combined) in 2000 for a conventional indemnity plan for single and family coverage was $3,211 and $7,746, respectively, for small firms with from 3 to 99 workers and $2,858 and $7,294 for firms with from 1,000 to 4,999 workers. The 6 to 12 percent difference in premiums between the small and larger firms is deceptive since the range of benefits covered and the cost-sharing requirements often differ, with smaller firms typically covering less. Nonetheless, the differences in costs are noteworthy since so many workers are employed in small firms and face a higher probability of not being offered coverage. Nationally, 40 percent of the workforce was self-employed or employed by firms with fewer than 100 workers in 1998 (Fronstin 2000).

For self-employed workers who must purchase coverage in the individual insurance market, the premiums are even higher than those quoted above. New York has standardized insurance plans in the individual market, with community rating by carriers, so the premiums vary by carrier and county. In general, premiums are higher in New York City and surrounding counties than in upstate New York.[3] Annual premiums for individual, single coverage in the direct-pay market in February 2001 ranged from approximately $2,900 to $5,400 for an HMO, with point-of-service (POS) premiums higher. Premiums for family coverage in the individual market ranged from about $7,000 to more than $12,000 for an HMO, with point-of-service premiums even higher. The self-employed cannot deduct the full premium for health insurance from their taxes.

New York's Experience with Insurance Subsidies

Healthy New York builds on a decade-old history of subsidized programs for small employers and low-income individuals. Before HCRA 2000, New York had three modestly funded programs to provide subsidies to small employers or low-income individuals to purchase health insurance, but the programs are being phased out as Healthy New York is fully implemented. Two of the programs—the Small Employer Subsidy Program, which became the New York State Health Insurance Partnership Program (NYSHIPP) under HCRA 1996, and the Individual Subsidy Program—consisted of five pilot projects initiated in 1989.

Small Employer Subsidy Program/NYSHIPP
Two pilots in the Small Employer Subsidy Program provided health insurance subsidies to small employers in Albany and Brooklyn. These pilots were redesigned under HCRA 1996 and funding was expanded so small firms throughout New York could apply for subsidies. Renamed the New York State Health Insurance Partnership Program (NYSHIPP), the expanded demonstration program provided subsidies of up to 45 percent of the premium costs for firms with fewer than 50 employees that had not offered group insurance coverage in the previous 12 months. Employees could be required to pay as much as 10 percent of the full premium but this choice was left to the employer. The employer could opt to pay the entire 55 percent of the premium remaining after the subsidy. Firms with low-wage workers were given preference in the selection of applicants for the subsidies. NYSHIPP was authorized to run for three years, from 1997 to 1999, and the state legislature allocated $6 million for the subsidies.[4]

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[3] New York's Insurance Department maintains a website that provides monthly updates of the premium rates by county for each carrier offering direct-pay coverage. See: http://www.ins.state.ny.us/ihmoindx.htm.

[4] When NYSHIPP was implemented, approximately 285,000 workers in New York were uninsured and working in small firms that did not provide health coverage. The goal was to enroll 22,000 of these workers (*Greater New York Hospital Association Report* 1999) but by 1998 only about 10 percent had enrolled (2,841 employee contracts were in effect, and dependents were permitted to be covered by each contract) through just over 1,000 participating firms. More than 300 additional firms were on a waiting list as well.

By January 1998, 28 carriers were selling policies under NYSHIPP, although they were not required to sell a standardized package of benefits. The types of policies offered under NYSHIPP included managed care products (from HMOs to point-of-service plans) and indemnity insurance plans. Premiums ranged from $87 to $265 for a policy covering one person, and from $197 to $1,000 for a family policy. The average subsidy per contract was $1,324 per year, and the average subsidy per small firm was $4,103 per year.

Individual Subsidy Program

The Regional Pilot Project (RPP) was established in 1989 to provide subsidies to individuals who had family incomes below 200 percent of the poverty level and who had been without any type of health insurance for at least six months prior to enrollment. The RPP had three pilots—in the Bronx; in a limited area on the west side of Manhattan; and in five contiguous counties north of Albany (Essex, Hamilton, Saratoga, Warren, and Washington).[5] In 1993, the state froze enrollment in the individual subsidy pilots because of fears that the program would exceed its budget that year. HCRA 1996 re-authorized funds for the pilots, with approximately $6 million per year through 1999 for subsidies. But it was not until late 1997 that the pilot account had surplus funds—due to more disenrollment than expected. The state then lifted the enrollment freeze, but, among the three pilots, only the Bronx Health Plan (BHP) elected to expand enrollment. Total enrollment under the Individual Subsidy Program was very small. For example, in the 1989–1993 period, BHP had a maximum enrollment of about 4,000 people, which fell to about 900 during the freeze on new enrollments. BHP began accepting new enrollees again in July 1998, and enrollment rose to about 2,800 people by the fall of 2000. Subsidies to individuals ranged from 30 to 90 percent of premiums. The BHP premium for adults with single coverage, for example, was about $200 per month in early 1999.

Voucher Program for Individuals

HCRA 1996 called for a program to offer vouchers redeemable for a limited health benefit plan. The pilot program had only two sites: Rensselaer and Westchester Counties. The Insurance Department ran the pilots, whereas the Department of Health ran NYSHIPP and the individual subsidy program. Individuals and families with household incomes below 222 percent of the poverty level, and who were not eligible for either Medicaid or Medicare and had been uninsured for at least one year were eligible for the vouchers. The benefit plan under the voucher program covered only outpatient services, with a 12-month waiting period for pre-existing conditions. The program was expected

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[5] The Bronx Health Plan administered the UniCare pilot in the Bronx with subcontracts to the Montefiore Medical Center and National Prescription Administration. Empire Blue Cross/Blue Shield administered the pilots in Manhattan (with a subcontract to St. Luke's Roosevelt Hospital Center) and in the upstate counties with a subcontract to Northcare.

to reduce utilization of hospital emergency departments because insured people would now gain access to primary and preventive care. Total funding for the voucher program was to have been $5 million per year for the 1997–1999 period, and the voucher amount per individual or family was to be no more than 80 percent of the premium. However, the program did not begin to enroll people until September 1999, and it was ended by HCRA 2000. People who had enrolled in the voucher program could enroll as qualified individuals under Healthy New York.

Thorpe et al. (1992) evaluated the pilot projects that preceded the NYSHIPP and individual subsidy programs authorized by HCRA 1996, finding that the effect of the subsidy for small employers was small to negligible. Many firms either did not know about the program or the subsidized premium was still "too high" (Thorpe et al., p. iii). Similarly, the subsidy for individuals did not attract nearly as many people as anticipated. The evaluators also found that "concerns that the projects would attract primarily uninsured people with severe medical problems were not borne out" (Thorpe et al., p. vi). However, Thorpe and colleagues had a difficult time obtaining good response rates from enrollees and it was hard to assess differences between enrolled people and those who were eligible but not enrolled.

II. FEATURES OF HEALTHY NEW YORK

Target Workers

Healthy New York has three parts—one for firms or businesses with 50 or fewer workers, one for low-income uninsured individuals who work, and a third for sole proprietors (independent contractors and self-employed individuals).[6] The component for small firms requires that the firm have at least 30 percent of its employees earning annual wages of no more than $30,000 and at least one of these employees must enroll in the health insurance offered.[7] Also, at least half of all the employees in the firm who are eligible for coverage must enroll.[8]

The component for uninsured individuals who work is available to:

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[6] The third category, sole proprietors, was added by amendments to the HCRA legislation and signed into law by Governor George Pataki on September 13, 2000. The amendments also permitted other exceptions to the requirement that people be uninsured for at least the prior 12 months (see note 9).

[7] The $30,000 annual wage figure is to be adjusted every July 1st by the rate of inflation used to adjust the annual poverty level of income, starting in July 2002.

[8] Persons working 20 hours or more per week are considered employees by Healthy New York. Also, to be eligible for Healthy New York, a worker cannot be eligible for Medicare.

- those with household incomes below 250 percent of the poverty level (the income eligibility ceiling is the same as that for Child Health Plus); see Table 1 at the end of this report for how different percentages of the poverty level translate to dollars, both in monthly and annual terms, for different family sizes.

- people who have not had health insurance coverage for the previous 12 months, and are not eligible for Medicare or employer-provided group insurance[9]

- people who are employed on a full-time or part-time basis, or are actors or other types of workers employed in non-traditional fields or on a project-by-project basis (people who have episodic employment)

The eligibility criteria for sole proprietors are the same as for individuals.

Similar Features Across Components
All the components of Healthy New York share certain similarities:

- the same basic benefits package (exempt from some state-mandated services, and with significant patient cost-sharing provisions)

- a requirement that the firm or the individual not have had health insurance during the previous 12 months. There are two general exceptions: if the firm "rolls over" from NYSHIPP or the individual "rolls over" from the Regional Pilot Programs or the Voucher Program; and if an individual has lost eligibility for coverage.[10]

- community rating of premiums, which for each contract tier (single, couple, family) must be the same for the small group and individual policies—i.e., the premium rates must be calculated using a pooled claims experience of the policies sold to small groups and individuals.

- a stop-loss mechanism to provide a subsidy of 90 percent of the benefits paid between $30,000 and $100,000 per person per calendar year, although the stop-

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[9] Exceptions to the requirement that someone not have had coverage in the preceding 12 months include: loss of employment due to factors other than voluntary separation, death of a family member resulting in termination of coverage, change to a new employer that does not provide coverage, discontinuation of a group health plan, expiration of COBRA coverage, legal separation/divorce or annulment, reaching the age of loss of dependency, and loss of eligibility for group health insurance coverage.

[10] See footnote 9 above.

loss funds operate separately for the small group policies and the individual/sole proprietor policies.

Up to 10 percent of the $219 million allocated for Healthy New York may be spent on "developing and implementing public education, outreach and facilitated enrollment strategies targeted to small employers and working adults without health insurance." Just over a quarter of these funds ($56 million) is allocated to the individual policies.

In addition, all HMOs in the state must participate in the program by offering the standardized Healthy New York policy. Not-for-profit and commercial insurers may also participate in the program but they are not required under HCRA 2000 to do so.

Healthy New York should also be seen in the context of what is available to small firms and individuals who are not eligible for the program. The small group market in New York does not have standardized benefits packages and does not require all carriers to participate. However, carriers offering health insurance to small groups must use community rating when setting premiums, so for a given health insurance policy with a set of benefits, a carrier must use the pooled experience of all persons covered by that policy in setting the premium rate. In addition, all health insurance policies sold to small groups must be offered on an open enrollment basis. Carriers must accept all applicants without regard to health status, although pre-existing medical conditions can be excluded for limited time periods.

The individual market in New York requires HMOs offering coverage in a county to participate in the individual market, just as they are required to participate in Healthy New York. There are two options for coverage in the individual market: an HMO plan and a point-of-service plan that permits greater choice of provider. Both options have standardized benefits packages, so individuals seeking coverage in the individual market do not have a larger choice of what benefits are covered and carriers cannot try to attract or discourage applicants on the basis of benefits offered. Carriers are required to community rate premiums in each county, and, as in the small group market, open enrollment is required.

Achieving Lower Premiums

Healthy New York premiums were expected to be lower than those available in the small group and individual markets, and they are. Three program design factors are responsible:

- a scaled-back, leaner package of covered benefits, with higher cost-sharing required of enrollees when they use services

- services covered only if they are obtained from a provider within the network

- perhaps most important, the stop-loss funds created by HCRA 2000 will be used to pay up to 90 percent of claims between $30,000 and $100,000 for an individual in a calendar year. In effect, this causes the state to assume the role of reinsurer.

Leaner Benefits and Higher Cost-Sharing

The Healthy New York package does not include the full range of benefits mandated for typical policies sold in the state's small group and individual markets. For example, mental health care, home health care, chiropractic care, and outpatient treatment for alcoholism and substance abuse are not covered. Because the package of benefits is leaner than those currently required in both the small group and individual markets, it costs less than the traditional policies.

The benefits package also requires higher cost-sharing. Table 2 summarizes the benefits covered and cost-sharing required under Healthy New York. For example, there is a $500 copayment per episode of inpatient care, a copayment for inpatient surgery equal to the lesser of $200 or 20 percent of the surgery costs, a $75 copayment for outpatient surgery. A prescription drug benefit requires a $100 annual deductible along with a $10 copayment per 34-day supply of a generic prescription, or a $20 copayment plus the difference in cost between the generic and brand-name drug, plus a $3,000 cap on total prescription drug coverage.[11] The cost-sharing at point-of-service is expected both to reduce the demand for some medical care and to shift some of the costs onto those who actually use care, thereby slowing the rate of increase in premiums for all enrollees. Also, the cap on total prescription drug expenditures is considered a feature that may attract employers who fear that rapidly rising pharmaceutical costs might otherwise cause health insurance to become too expensive in a short period of time.

In-Network Requirement

Services are only covered if they are obtained from the carrier's network of providers. The networks have negotiated fees that are below market reimbursement rates. By requiring enrollees to obtain services within the network, carriers can manage care more efficiently, reducing costs and premiums. Requiring enrollees to obtain services within a network also distinguishes Healthy New York from the point-of-service option in the individual market.

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[11] The cost-sharing provisions were set in the legislation creating Healthy New York, although the Superintendent of Healthy New York is permitted to modify, by regulation, the copayment and deductible amounts on or after January 1, 2002.

Stop-Loss Provision

The inability to predict a person's medical costs constitutes the largest source of risk for carriers. Consequently, the primary reason for lower premiums under Healthy New York is the creation of stop-loss funds, eliminating the carriers' need for funds to cover up to 90 percent of the annual claims between $30,000 and $100,000 for any individual. About 1 percent of the insured population has medical care expenses in excess of $30,000 in a given year.[12] The very high costs of this subset of people is what exposes carriers to risk— the risk that they may not have sufficient premium revenues to pay the claims.

Under the innovative stop-loss feature of Healthy New York, the state assumes the role of a reinsurance company so that carriers may purchase less reinsurance.[13] They are at risk for only 10 percent of costs for annual expenditures between $30,000 and $100,000 per enrollee.

It is important to note that carriers are not totally protected if claims for high-cost people exceed the funds allocated for stop-loss funds in a calendar year. Any allocated funds left unspent at the end of a year may be carried over to the stop-loss pool for the following year, but if claims exceed the stop-loss funds available in a year, the funds are distributed in proportion to the claims submitted. Thus, in setting premiums, carriers may have been cautious in their expectations of how many enrollees will actually have claims in the $30,000 to $100,000 range.

To guard the stop-loss pools from the threat of claims exceeding available funds, HCRA 2000 legislation permits the Superintendent of Healthy New York to suspend enrollment of new small businesses or new individuals if it is determined that total enrollment in either part of Healthy New York will cause the stop-loss funds to exceed claims against either fund. Table 3 indicates the funds available for the stop-loss pools in 2001, 2002, and the first six months of 2003.[14]

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[12] Based on estimates in a memo from Cathi Callahan of Actuarial Research Corporation to Sherry Glied of the Mailman School of Public Health at Columbia University, dated 12 September 2000. The memo was requested as part of the Commonwealth Fund's project on increasing health insurance for working Americans.

[13] HCRA 2000 permits the Superintendent of Healthy New York to use a portion of the stop-loss funds to purchase stop-loss insurance or reinsurance, for either or both of the stop-loss funds, from an insurance company licensed to write such insurance in New York. The state either can act as a reinsurer or it can itself purchase reinsurance protection. At least for the initial year of Healthy New York, the Superintendent determined that purchasing a reinsurance policy was not a feasible approach.

[14] See Paragraphs (G), (H), and (I) of Section 84 of HCRA 2000. The monies for the stop-loss funds for Healthy New York as well as the individual market are from the tobacco control and initiatives pool. The Commissioner of Insurance is responsible for the distribution of these funds.

HCRA 2000 also created a stop-loss fund for the individual market that is similar to the two stop-loss pools for Healthy New York, as also shown in Table 3. The individual market stop-loss fund was available to carriers for high claims in calendar year 2000 as well as the Healthy New York years 2001–2003. The individual market stop-loss funds reimburse carriers for 90 percent of annual claims between $20,000 (not $30,000 as in Healthy New York) and $100,000 for an individual. Two types of standardized policies are in the individual market: an HMO plan and a point-of-service plan. Not surprisingly, premiums for the POS plans are generally higher than the premiums for the HMO plans. The stop-loss funds allocated to the individual market are evenly divided between the two types of plans, although the statute permits the Superintendent of Healthy New York to transfer monies between the two funds in a given year if there is a shortfall in one and a surplus in the other.[15]

Including stop-loss funds for the individual market in HCRA 2000 is key to obtaining lower premiums for Healthy New York. The creation of the stop-loss fund and permitting its use in 2000 indicate an awareness among legislators and the Insurance Department that carriers in the individual market were incurring losses. Clearly, without some relief from their individual market losses, it would have been difficult to require these carriers to offer policies under Healthy New York at substantially reduced premiums. The carriers would have had a strong incentive to set Healthy New York premiums close to those for the individual market plans and then offset their individual market losses with revenues from Healthy New York policies. In addition, if the losses in the individual market were not offset and the Insurance Department permitted the carriers to raise rates accordingly, there was some danger that the individual market would go into a death spiral, harming carriers' financial status. The number of uninsured might also increase if carriers exit the market or if people cannot afford rapidly escalating rates.

Community Rating of Premiums

Premiums for both the small employer and qualified individuals/sole proprietor parts of Healthy New York are jointly community rated by each carrier participating in the program. Although there are two separate stop-loss pools, the joint experience of people enrolled in the two components is used to determine the premium. Each carrier sets its own premium for each of the contract tiers offered (single, couple, adult with children, family), subject to approval from the Insurance Department based on its claims experience.[16]

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[15] See Sections 4321-A and 4322-A of HCRA 2000.
[16] It is not clear whether the carriers can pool the claims experiences of the contract tiers or can keep each of the contract tiers separated in determining premiums.

Although premiums for the small group and individual components of Healthy New York are community rated, there are differences in the effective premium. In the small group part of Healthy New York, employers must pay at least 50 percent of the premium and must contribute the same amount for all employees. In the individual and sole proprietor parts of the program, the individual/sole proprietor must pay the entire premium—no direct subsidy is available based on a sliding scale related to income. A person in a family of four, for example, with an annual income of 200 percent of the poverty level ($35,208 in 2000) pays the same premium as a person in a family of three with an annual income at the poverty level ($14,580 in 2000) for an individual (single tier) contract.

Healthy New York Premiums

Compared with the individual market HMO premiums, Healthy New York premiums are indeed lower. Table 4 compares the premiums in a subset of counties under Healthy New York and the individual market HMO plan for February 2001.[17] Table 5 shows Healthy New York premiums as a percent of individual market premiums for the various contract tiers for the HMOs in each of the counties in Table 4. For the most part, HMOs were offering the policies at premiums 30 to 50 percent less than the individual market HMO policies (which are also standardized benefits policies). In a few cases, the discounts are even greater—some HMOs have set their Healthy New York premiums close to 30 percent of the individual market premiums.

It is difficult to compare the premiums under Healthy New York to those for small firms in the small group market because the small group market does not have a standardized benefits policy. Rates for small firms are based on the benefits and cost-sharing structure chosen by the firm as well as the risk profile of all the people (employees and dependents) covered by the policy. By one comparison, the premiums available in February 2001 were about 85 to 90 percent of premiums small firms might obtain in the small group market (*Crain's New York Business,* Feb. 19, 2001). However, this comparison does not take into account higher enrollee cost-sharing typically required of the less expensive, indemnity small group policies. If Healthy New York premiums are compared to HMO products available in the small group market, they are 15 percent to 30 percent lower.

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[17] For a full listing of each county's Healthy New York premium offerings by HMO and each county's individual market premium offering by HMO, go to the Insurance Department website: http://www.ins.state.ny.us/healthyny. As can be seen from the website, there is substantial variation in the premiums at which the Healthy New York policies are being offered, even within the same county.

Some of the initial complaints about Healthy New York premiums for small firms came from firms that previously had NYSHIPP subsidies of up to 45 percent of what they could obtain in the small group market. These effective rates could easily have been lower than Healthy New York premiums if the firms chose indemnity policies with high copayments. But only a very small number of firms were able to obtain subsidies under NYSHIPP. Many more small firms are eligible for Healthy New York. Equally important, simply expanding the funds for NYSHIPP would not have given the state the ability it has under Healthy New York to control health insurance costs for small firms.

Two additional points about Healthy New York premiums are pertinent. First, because premiums for people in the individual/sole proprietor and small group parts of Healthy New York are community rated, those for qualified individuals equal the per person premiums for workers in small firms. However, workers in small firms pay no more than half of the premium since HCRA 2000 requires employers to pay at least 50 percent. Hence, the much larger reduction in the premium for individuals (relative to the reduction for workers in qualified small firms) achieved by Healthy New York needs to be seen in the context that workers in small firms have an effective premium that is only half that faced by qualified individuals and sole proprietors.[18]

Second, although premiums for qualified individuals and sole proprietors are less than those available in the individual market, they still account for a large proportion of before-tax income for these groups. Table 6 shows the premium costs as a percent of family income in selected counties, using the lowest premium available for the policy type and assuming that everyone in the family is covered by the policy. Table 7 shows the premium costs as a percent of family income for the same selected counties but assumes that only one person in each family is covered. If everyone in the family is covered, premium costs as a percent of family income before taxes are generally over 10 percent at the highest eligible income levels. At the lower eligible income levels, the premium accounts for 20 percent or more of the individual's or family's income before taxes. When only one person in the family is covered by a policy, the lowest available premium represents 3.3 percent or more of before-tax family income—and that is the highest eligible income. In general, even the premium for a single policy accounts for 8 percent or more of a family's income—and for people with incomes below 150 percent of the poverty level, the premium represents more than 10 percent of the before-tax income. For comparison, people with employer group coverage generally pay less than 5 percent of their income for their share of the premiums, and dependent coverage is usually included.

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[18] Of course, to the extent that the employer share of the premium is truly "paid" by employees in the form of forgone earnings (the viewpoint of most economists), then the 50 percent effective premium for workers in small firms is just a fiction designed to make health insurance attractive to workers.

People who qualify as individuals for Healthy New York generally cannot afford even the reduced premiums. Whether low-income workers in small firms will decide that the premiums for Healthy New York are affordable will become clearer next year. The relative magnitudes of the stop-loss funds for the individual/sole proprietor and small-firm parts of Healthy New York imply expectations that the program will appeal primarily to workers in small firms.

III. LIKELY OUTCOMES OF HEALTHY NEW YORK

Will Healthy New York substantially reduce the number of working uninsured and their dependents in New York? After only 11 months of operations, it is still too early to know how many people will enroll. Earlier studies of low-income individuals and small firms that were offered reduced premiums for health insurance indicate that, at least initially, the lower Healthy New York premiums are not likely to create great demand among eligible people.[19]

In general, the evidence shows that modest changes in premiums—say, reductions of 10 to 15 percent—generate even smaller percentage changes in the numbers of firms or individuals who purchase insurance.[20] This evidence comes from small programs targeted at very low-income people who are not eligible for Medicaid. The subsidies in these programs frequently equal close to 90 to 95 percent of the premium for the poorest people, and then the subsidies decline rapidly for higher income people. Not surprisingly, most of those who enroll are eligible for the largest subsidies (Ku and Coughlin 1999/2000; Swartz and Garnick 2000a) because, for eligible people with higher incomes, the less subsidized premiums represent a large share (10 percent or more) of their income. The general consensus from the research literature is that subsidies that reduce premiums by 10 to 15 percent will induce a yet smaller percentage of low-income uninsured individuals and small firms to purchase health insurance. Very little evidence exists about the effects of changes in premiums that are of greater magnitude than the 10 to 15 percent reduction range for people who have relatively low income. However, the finding that there is a sharp drop-off in take-up of insurance once premiums account for more than 5 percent of people's income implies that people's responsiveness to declines in premiums is closely linked to their calculation of the fraction of income that health insurance expenditures represent.

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[19] Participants knew that previous demonstration programs for small employers (including the pilot projects in New York) would be of limited duration. Therefore, many employers may have declined to participate simply because they did not want to face higher costs if the programs were not continued (Thorpe et al. 1992, Morrisey et al. 1994).

[20] A more extensive review of the empirical literature on price elasticity of demand for health insurance by small firms and low-income individuals is available on The Commonwealth Fund's website at www.cmwf.org.

Small Firms' Decision to Offer Coverage

As policymakers recognized when developing Healthy New York, two sets of decision-makers in small firms determine how many workers obtain health insurance: the firm's managers, and the workers. Managers decide whether or not to offer coverage to employees, and employees then decide whether or not to sign up. Managers are more likely to offer coverage if workers in the competitive labor market expect insurance to be part of the compensation package. Managers are also more likely to offer coverage if premiums (after tax subsidies) are affordable. For workers in small firms, the decision to enroll for coverage depends on the actual premium they pay, which is determined mostly by their share of the total premium.[21] In Healthy New York, employers are required to pay at least half the premium, and all employees within a firm must pay the same amount for the same type of policy (single, husband/wife, adult and children, family).

Empirical studies on these two parts of the decision process confirm that the choice to offer coverage depends on firm size (even in firms of fewer than 100 workers) and workers' incomes. Similarly, these studies show that workers' decisions to enroll depend on their incomes and the percentage of workers within a firm who earn low wages. Whether small firms offer health insurance appears to be sensitive to the fraction of low-wage workers.

Demand for Coverage by Individuals

In estimating how many individuals and sole proprietors might purchase non-group coverage, the income of eligible people is especially important. Most uninsured workers have low incomes with limited ability to respond to 10 or 20 percent reductions in premiums. Most studies of demand for individual coverage confirm that low-income people have minimal response to premium reductions. This finding no doubt reflects the comparatively large percent of income that premiums, even subsidized premiums, account for among low-income people.

The results from the studies by Ku and Coughlin (1999/2000), Swartz and Garnick (2000a), and Thorpe (1997) are particularly pertinent to estimating the likely

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[21] The effective premium is also determined by a worker's marginal income tax rate, so that the proportion of the premium "paid" by the employer may represent substantially more income than just the nominal premium payment when the tax implications of the employer's premium contributions are taken into account. The effective premium to employees differs by the income tax rate of workers. If an employer's contribution to the premium is paid in lieu of a wage increase, the employer's contribution represents more after-tax income for the high-wage workers than it does for the low-wage workers because tax rates are higher for high-wage workers. On the other hand, employees pay their share of the premium with after-tax income so high-wage workers face a higher effective out-of-pocket price for coverage than do low-wage workers. How many workers in small firms think about how their marginal income tax rate affects their effective premium is not clear, however.

effects of the Healthy New York premiums on qualified individuals. These studies all focused on low-income individuals' responses to subsidized state programs. It is very clear that poor people do not purchase health insurance when it costs more than 5 percent of their income. Ku and Coughlin found that, as premiums increased from 1 to 3 percent of family income, participation rates fell from 57 percent to 35 percent, and at 5 percent of income, participation fell to 18 percent of eligible people. Swartz and Garnick found that participation by people eligible for a subsidy dropped sharply once the subsidized premium represented more than 5 percent of their income. Thorpe concluded that participation rates decline from 75 percent in a free plan to 40 percent when a contribution equals 6 to 10 percent of income. Given the income percentages of Healthy New York premiums shown in Tables 6 and 7, most qualified individuals are unlikely to purchase policies that would cover more than one person in their family. Moreover, those with incomes below 200 percent of the poverty level are not likely to purchase even a single person policy.

IV. IMPROVING THE DESIGN OF HEALTHY NEW YORK

New York State policymakers deserve much credit for their innovative approach to reducing health insurance premiums for individuals, sole proprietors, and small firms. Their approach is in contrast to that of most other states and many federal policymakers, who have typically assumed that the best way to encourage individuals and small firms to buy coverage is to provide subsidies that reduce their effective premium. Most carriers have not been enthusiastic about these subsidies because they maintain that, with adverse selection an important factor in the individual and small group markets, unexpectedly high costs often necessitate higher per capita premiums than for people in large groups. Subsidies to individuals and small firms do not address this problem.

Although the design of Healthy New York does address the issue of carriers' risk from adverse selection, the current premiums may not attract large numbers of uninsured New Yorkers who are eligible for the program. But it is possible that minor adjustments to the current structure of Healthy New York would make it more attractive to more working uninsured and small employers. Three major options might be considered:

Option 1: Give Direct Subsidies to Individuals to Purchase Coverage

Workers in small firms that enroll in Healthy New York have a distinct advantage over individuals who do not have an employer offering Healthy New York: the employer pays at least half of the premium, paring the employee's share to under 5 percent of income for most workers. However, for individuals and sole proprietors, Healthy New York premiums exceed 5 percent of income, pointing up an inherent tension between two goals of Healthy New York: encouraging low-income people to obtain coverage through

employers and reducing adverse selection among individuals by lowering their premium to what workers in small firms pay.

Since even the low Healthy New York premiums are likely to be viewed as unaffordable by many eligible individuals, to encourage more people to enroll the program could provide direct subsidies to sole proprietors and individuals (who must have family incomes below 250 percent of the poverty level to qualify). The effective premiums for individuals should be close to those for low-income workers in small firms. In addition, to discourage employers from deciding their employees would be better off obtaining coverage as individuals, subsidies (smaller than those for individuals) could be available to very low-wage workers whose employers enroll in Healthy New York.

By equalizing the effective premiums for workers in small firms and individuals/sole proprietors, adverse selection among the individuals would decline. This is important since premiums for small firms and individuals are community rated together. If the risk pool for individuals is worse than that for people from small firms, the owners and workers in small firms will be cross-subsidizing the individuals.[22] Premiums for people in small firms would be higher than if the risk levels of the two pools were the same. Having workers in small firms bear the burden of higher costs of individuals is not an equitable way to distribute that burden. Higher premiums resulting from community rating could also lead healthy workers in small firms to forgo enrollment in Healthy New York. Then, because healthier people become less likely to enroll, the average costs of those who do enroll will be higher, as will premiums.

Providing direct subsidies to individuals to keep the effective premium for individuals about the same as for low-income workers in small firms would help maintain lower premiums for everyone. Enrollment in Healthy New York would increase as a result.

Funds for the subsidies should ideally come from the state so that everyone with the same income could receive the same amount no matter where they live. Proposals now exist for subsidy funds to come from foundations or large employers in certain regions or counties of the state, but if these funds are used with Healthy New York, especially for small firms, then they would go disproportionately to people who live in counties with local subsidy funds. This raises questions of equity since not all counties

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[22] More specifically, to the extent that the wages of workers in small firms do not rise as fast as they would in the absence of health coverage, the workers—rather than the owners—are cross-subsidizing the individuals. While consumers who buy the products or services of the small firms would be cross-subsidizing the individuals if demand for the products or services were relatively price-inelastic, most small firms do not face inelastic demand for their products or services.

have equal financial resources. Instead, it ought to be possible to pool such subsidy funds for statewide use.[23]

Simulations could determine the total cost of subsidizing qualified individuals and sole proprietors directly. But the subsidies must be high enough to ensure that low-income people eligible for Healthy New York will not pay a higher proportion of their incomes for coverage than do most middle-income people. They should not pay more than 5 percent of their income for coverage of the entire family.

The healthier people are clearly important for maintaining a less risky risk pool and lower premiums. If direct subsidies can bring healthier people into Healthy New York and promote equal risk pools of individuals and small firms, the benefits will exceed the additional administrative costs. More people will have health insurance.

Option 2: Adjust the Reinsurance Trigger

The stop-loss structure provides relief to any carriers that end up with annual claims between $30,000 and $100,000 for an individual. This design contains incentives for carriers to restrain health care costs so they do not exceed $30,000 (since carriers are still responsible for 10 percent of any claims above $30,000) and strong incentives for the cots to be held under $100,000. But if the total claims from all carriers for high-cost expenditures exceed the stop-loss funds available in a given year, the claims will be paid on a proportional basis. Carriers might reasonably be concerned that their share of claims between $30,000 and $100,000 could be more than 10 percent.

More importantly, the stop-loss structure does not eliminate the risk that a carrier may end up with a disproportionate share of claims above $100,000.[24] If this happens, a carrier would have to request higher premiums the following year to recoup losses not covered by the stop-loss mechanism. The higher premiums would prompt lower-risk enrollees to shift to other carriers. With the high-risk enrollees remaining, the carrier might easily enter a death spiral under Healthy New York in a short time. Such an upward spiral of costs over revenues for Healthy New York enrollees would also hurt the carrier's financial well-being and affect its other policyholders.

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[23] Alternatively, the state might run a demonstration in regions or counties that have raised funds from foundations or large employers to determine if direct subsidies do lower effective premiums sufficiently to increase enrollment.

[24] Annual claims above $100,000 account for 9.2 to 11.7 percent of all per capita health care expenditures, according to estimates by the Actuarial Research Corporation, Memo of 12 September 2000 to Sherry Glied for The Commonwealth Fund Task Force on the Future of Health Insurance.

If it turns out that a fair number of Healthy New York enrollees have claims above $100,000, the state will need to adjust the stop-loss mechanism. Without such an adjustment, carriers will not be able to maintain lower premiums.

Analyses of per capita health care expenditures from the Medical Expenditure Panel Survey data indicate that although only 1 percent of all nonelderly people covered by health insurance have annual expenditures above $30,000, total claims for this small group account for 28 percent of total health care expenditures.[25] If Healthy New York's stop-loss funds were to cover all claims (starting with the first dollar) for enrollees who have annual claims above $30,000, premiums might be reduced by about 28 percent even before other adjustments for the benefits package were taken into account. But covering all claims removes incentives for carriers to manage care and control costs. Carriers should still be required to pay some portion of the claims. They could be required to pay different portions of claims as total claims costs increase—perhaps 50 percent through $50,000, then 25 percent between $50,000 and $150,000, and then nothing beyond that. This example limits a carrier's liability for a high-cost enrollee to $50,000. By removing the risk of very high-cost claims for carriers, such an approach would stabilize premiums.

Adjusting the reinsurance mechanism may require more funds than originally allocated to the stop-loss pool from tobacco settlement funds or other state revenues. But if the state takes on more of the risk of high-cost claims, all taxpayers in the state would share the burden of high-cost enrollees (Swartz 2001).

Option 3: Choice Among Benefits Packages
HCRA 2000 legislation permits the Commissioner of Insurance to add benefits packages under Healthy New York after its first year of operations. While the legislation specified details of the original benefits package, the Insurance Department has the authority to design and offer additional policy choices. One of the initial complaints about Healthy New York is that the benefits package is "one size fits all." Some small firms and business groups would like a wider selection of policies, such as those available in the regular small group market or through purchasing alliances in some regions of New York. For example, the New York Purchasing Alliance would like to offer its HealthPass products to small firms in New York City that are eligible for Healthy New York.

The primary advantage of having only one benefits package is that when an enrollee has annual claims above $30,000, it is clear that the person is very sick. If people have a choice of benefits packages with different types of services covered by different

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[25] Ibid.

policies, then it could be argued that some people with high expenditures incurred them because of the more generous policies. Moreover, the carriers participating in Healthy New York are all HMOs that can more tightly control expenditures because enrollees have to obtain care from the HMOs' networks of providers. In contrast, when there are different benefits packages and differences in types of providers, it is harder to allocate stop-loss funds across carriers and policy types to ensure that the funds are truly used to reimburse carriers with very sick enrollees. When benefits packages differ in their covered services, the more generous policies by their very nature encourage people to use more health care.

Standardized benefits packages also let high-cost people obtain coverage they otherwise might not be able to find in a market with a choice of policies. Standardized policies pool low-cost and high-cost people, increasing the premium for the former but reducing it for the latter. The advantage for the high-cost group clearly comes at a price to low-cost people, although the size of the cost declines as the proportion of low-cost enrollees increases. If almost all of the enrollees are low-cost, the per enrollee additional cost of the high-cost enrollees would be quite small.

Lower premiums are essential to attract low-cost people, given all we know about their demand for health insurance. The standardized benefits package of Healthy New York, with its leaner package of benefits and higher cost-sharing, was designed to keep the premium low. However, studies of small employers and workers indicate that most people want a health insurance policy to provide a wide range of benefits and not require high cost-sharing (McLaughlin 1993). A tension exists between increasing covered benefits, including reducing cost-sharing, and keeping premiums low. We do not know whether more healthy people would enroll in Healthy New York if the benefits package covered mental health and substance abuse services and chiropractic care and/or had lower copayments. If enriching the benefits package and lowering copayments would attract low-risk people, the risk pool of all enrollees would be lower, reducing premiums as well. No one can be certain that adding another benefits package choice in 2002 would attract additional healthy people to Healthy New York, but there seems to be support for offering both a choice of benefits packages and for trying to attract more healthy people. If Healthy New York offers a second benefits package, all HMOs should be required to offer both benefits packages.

Healthy New York relies on the state to act as reinsurer. While it is easier to manage the reinsurance role by having only one benefits package, there is nothing magical about having only one threshold (in this case $30,000) for when the reinsurance comes

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into play. Different threshold levels could be chosen to target very sick people according to the actuarial experience with different packages of benefits. If the state decides to offer another benefits package to increase enrollment in 2002 (and perhaps a third package in 2003), it would not have to reject the reinsurance principle that distinguishes Healthy New York. To make the reinsurance process manageable, however, the Insurance Department needs to limit the number of choices to just a few.

In the New York City region, especially, some have proposed that, instead of expanding the choices of benefits packages, the regulations implementing Healthy New York should be changed to allow small firms to offer Healthy New York as one of the choices they offer employees (for example, through HealthPass). But then the healthier employees might select a non-Healthy New York plan and Healthy New York would be left with a riskier pool, making carriers reluctant to participate in Healthy New York. Moreover, Healthy New York was targeted at small employers that were not offering coverage. The objective is to increase health insurance coverage among low-income individuals and workers who have not had the option of insurance. Healthy New York, with its limited public funds, should not be an option for small firms that are already offering choices.

V. CONCLUSION

Healthy New York's innovative approach to reducing health insurance premiums is designed to attract the working uninsured and their dependents. By reducing insurance carriers' exposure to large numbers of very high claims, Healthy New York removes much of the need for per capita premiums in the individual and small group markets to be priced so much higher than those in larger groups. Essentially, the state is taking on the role of reinsurer to carriers for 90 percent of the costs of people with annual claims totaling $30,000 to $100,000.

The Healthy New York approach deserves attention from policy analysts and policymakers. It is based on the principle that high-cost health insurance claims should not be borne only by people who already have individual or small-group coverage. Rather, by spreading this burden more widely, it is hoped, people who have individual or small-group coverage will not have to drop that coverage because of rising premiums caused by the higher costs of newly insured people entering the market. Everyone in the state benefits by having more people with health insurance coverage. The costs of this benefit should therefore be spread across the population as broadly as possible.

The initial reduction in premiums achieved by Healthy New York is greater than many had anticipated, given estimates of the proportion of all medical expenditures

accounted for by people with claims of $30,000 to $100,000. Healthy New York premiums are, for the most part, from 30 to 50 percent less than individual market premiums—a substantial savings for adults who otherwise would have to seek coverage in the individual market. Similarly, premiums are 15 to 30 percent below comparable HMO policies available to small firms in the small-group market.

How enrollment proceeds this year and next will tell us whether Healthy New York premiums are low enough to attract large numbers of the low-income working uninsured. On one hand, there are concerns that the premiums may still be too high to attract the numbers of people eligible for the program. The initial premiums available represent more than 5 percent of income for a large share of people who are the intended enrollees. On the other hand, the state's efforts to promote the program's lower premiums may encourage eligible uninsured workers to enroll.

Three modifications might be considered for Healthy New York if enrollment does not approach target levels by the end of the program's first year:

- Direct subsidies could be made available to individuals and sole proprietors who are eligible for Healthy New York so as to equalize the effective premium faced by small-business workers and individuals/sole proprietors.

- The program could adjust the reinsurance mechanism if it turns out that some carriers have disproportionately high numbers of enrollees with very high claims (above $100,000) after the initial year. The reinsurance mechanism could be modified so that more of the risk of high-cost claims is shifted to the state.

- The program could offer an additional standardized benefits package in 2002, primarily to attract more young and healthy uninsured workers.

These adjustments are directed at further reducing the effective premiums and expanding the benefits options so that more eligible people might enroll. They are not, however, directed at altering the basic approach of Healthy New York—having the state act as reinsurer for high-cost enrollees in order to subsidize health insurance for low-income people. The program's current design spreads the costs of subsidizing the uninsured so that no one group of insured people bears most of the burden. This should be the guiding principle for any future plans to modify Healthy New York.

Table 1. Incomes by Poverty Level and Family Size of Individuals and Sole Proprietors Eligible for Healthy New York

Monthly Incomes of Individuals and Sole Proprietors:

	Family Size				
Poverty Level	1	2	3	4	5
Poverty Level	$ 716	$ 968	$1,219	$1,471	$1,723
150%	1,074	1,451	1,829	2,207	2,584
200%	1,432	1,935	2,438	2,942	3,446
250%—Maximum	1,790	2,419	3,048	3,678	4,307

Annual Incomes of Individuals and Sole Proprietors:

	Family Size				
Poverty Level	1	2	3	4	5
Poverty Level	$ 8,592	$11,616	$14,628	$17,652	$20,676
150%	12,888	17,412	21,948	26,484	31,008
200%	17,184	23,220	29,256	35,304	41,352
250%—Maximum	21,480	29,028	36,576	44,136	51,684

Table 2. Summary of Benefits and Cost-Sharing for Healthy New York

Benefit	Cost-Sharing
Inpatient hospital services (daily room & board, general nursing care, special diets, misc. hospital services & supplies)	$500/episode
Outpatient hospital services, including diagnostic & treatment services	$20 copay
Physician services, including diagnostic & treatment services, consultant & referral services, surgical services (including breast reconstruction services after a mastectomy), anesthesia services, second surgical opinion, second opinion for cancer treatment	surgical services copay of *lesser* of 20% of cost or $200/occurrence
Outpatient surgical facility charges related to a covered surgical procedure	$75/episode
Preadmission testing	$20 copay
Maternity care	$10 copay/visit
Adult preventive health services, including mammography screening, cervical cytology screening, periodic physical exams no more than once every 3 years, adult immunizations	$20 copay
Preventive & primary care services for dependent children, including routine well-child visits & necessary immunizations	$20 copay
Equipment, supplies & self-management education for treatment of diabetes	$20 copay
Diagnostic X-ray and laboratory services	$20 copay
Emergency room services	$50, waived if visit results in admission
Therapeutic services, including radiology services, chemotherapy, and hemodialysis	$20 copay
Blood & blood products furnished in connection with surgery or inpatient hospital services	$20 copay
Prescription drugs obtained at participating pharmacy or mail order prescription drug program utilized by an HMO	$100 deductible/year, $10/34-day supply of generic, $20/34-day supply of brand-name drug plus difference in cost of brand-name & generic; if using mail order firm, $20/90-day supply of generic, $40/90-day supply of brand-name plus difference in cost of brand-name & generic; copay cannot exceed cost of drug maximum benefit $3,000 per year

**Table 3. Stop-Loss Funds Available to Individual Market and
Healthy New York Individuals and Small Employers, 2000–03**

Individual Market Stop-Loss Funds

2000	$35 million
2001	$36 million
2002	$39 million
January–June 2003	$20 million
Total	$130 million

Qualified Individuals HNY Stop-Loss Funds

2001	$6 million
2002	$29 million
January–June 2003	$21 million
Total	$56 million

Qualified Small Employers HNY Stop-Loss Funds

2001	$34 million
2002	$77 million
January–June 2003	$52 million
Total	$163 million

Table 4. Comparison of Healthy New York Premiums with Individual Market Premiums for HMO Policies, by HMOs in Seven Counties, February 2001

	Healthy New York				Individual Market: HMO Plan			
	Individual	Couple	Adult and Child	Family	Individual	Couple	Adult and Child	Family
Albany County								
Capital District Physicians' Health Plan	$155.73	$327.03	$264.74	$412.68	$294.13	na	na	$764.74
Empire BlueCross BlueShield Healthchoice	$181.44	$362.88	$326.59	$544.32	$251.87	$503.75	$453.38	$755.63
GHI HMO Select	$160.03	$355.97	$304.06	$466.13	$356.83	na	na	$909.91
Healthnow New York	$151.21	$309.98	$302.42	$429.44	$363.05	na	na	$943.97
MVP Health Plan	$151.58	$303.17	$295.62	$435.65	$490.66	$981.31	$805.38	$1,313.58
Cayuga County								
Excellus	$186.55	$406.69	$306.77	$561.78	$297.33	na	na	$744.33
Aetna U.S. Healthcare	$185.20	$370.60	$327.20	$547.40	$282.40	$564.80	$499.90	$839.30
UnitedHealthcare of Upstate New York	$211.67	$465.89	$370.42	$604.53	$306.70	na	na	$857.23
Univera Healthcare–CNY	$192.00	$384.00	$518.40	$518.40	$303.31	na	na	$788.61
Genesee County								
Excellus	$178.05	$438.97	$357.87	$471.19	$270.88	$541.76	na	$812.63
Healthnow New York	$119.69	$245.36	$239.38	$377.50	$259.53	na	na	$717.96
Independent Health Association	$138.00	$278.00	$243.50	$407.56	$244.89	na	na	$678.99
Univera Southern Tier	$141.56	$294.44	$369.19	$369.19	$270.23	$540.48	na	$704.79
Preferred Care	$192.41	$402.13	$369.04	$510.59	$283.10	$452.97	na	$651.14
Univera Healthcare–WNY	$141.56	$303.69	$265.09	$451.75	$271.07	$542.19	$490.35	$873.06

	Healthy New York				Individual Market: HMO Plan			
	Individual	Couple	Adult and Child	Family	Individual	Couple	Adult and Child	Family
New York County (Manhattan)								
Atlantis Health Plan	$193.48	$386.97	$379.23	$580.45	$363.03	$726.00	$711.48	$1,089.00
CIGNA Healthcare of New York	$213.33	$426.66	$395.13	$631.56	$367.01	$734.03	$623.92	$1,101.04
Empire BlueCross BlueShield Healthchoice	$205.00	$410.00	$369.00	$615.00	$335.83	$671.66	$604.49	$1,007.49
GHI HMO Select	$196.46	$437.01	$373.28	$572.25	$455.51	na	na	$1,161.57
HIP Health Plan of New York	$211.51	$444.18	$370.15	$609.59	$274.38	$548.76	na	na
Horizon Healthcare of New York	$200.70	$401.40	$361.26	$609.27	$656.06	na	na	$1,837.00
MagnaHealth of New York	$224.70	$449.41	$428.79	$676.17	$319.95	$639.92	$559.94	$959.89
Managed Health	$216.93	$433.64	$383.75	$644.28	$351.14	$701.91	$621.17	$1,042.86
MetroPlus	$260.30	$559.50	$456.45	$755.65	$397.58	$850.91	$710.55	$1,163.88
Oxford Health Plans NY	$222.05	$488.50	$421.89	$703.89	$317.06	$634.12	$618.27	$951.18
Physician Health Services of New York	$238.79	$525.35	$441.77	$716.38	$387.98	$775.98	$702.59	$1,090.57
Aetna U.S. Healthcare	$205.80	$411.80	$363.60	$608.20	$313.80	$627.60	$555.40	$932.60
UnitedHealthcare of New York	$227.41	$474.15	$388.19	$679.27	$347.26	$694.52	$678.55	$1,031.36
Orange County								
Capital District Physicians' Health Plan	$183.76	$385.90	$312.39	$486.96	$355.72	na	na	$924.87
CIGNA Healthcare of New York	$213.33	$426.66	$395.13	$631.56	$367.01	$734.03	$623.92	$1,101.04
Empire BlueCross BlueShield Healthchoice	$181.44	$362.88	$326.59	$544.32	$302.25	$604.05	$544.05	$906.76
GHI HMO Select	$175.50	$390.38	$333.45	$511.20	$398.58	na	na	$1,016.38
HIP Health Plan of New York	$211.51	$444.18	$370.15	$609.59	$274.38	$548.76	na	na
Horizon Healthcare of New York	$200.70	$401.40	$361.26	$609.27	$519.50	na	na	$1,454.60
MVP Health Plan	$175.06	$350.13	$341.41	$503.13	$517.46	$1,034.93	$849.38	$1,385.36
Oxford Health Plans NY	$222.05	$488.50	$421.89	$703.89	$317.06	$634.12	$618.27	$951.18
Physician Health Services of New York	$241.14	$530.50	$446.10	$723.41	$335.23	$670.49	$607.07	$942.30
Aetna U.S. Healthcare	$205.80	$411.80	$363.60	$608.20	$313.80	$627.60	$555.40	$932.60
UnitedHealthcare of New York	$206.18	$429.89	$351.95	$615.86	$301.07	$602.14	$588.29	$894.18

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	Healthy New York				Individual Market: HMO Plan			
	Individual	Couple	Adult and Child	Family	Individual	Couple	Adult and Child	Family
Suffolk County								
CIGNA Healthcare of New York	$213.33	$426.66	$395.13	$631.56	$367.01	$734.03	$623.92	$1,101.04
Empire BlueCross BlueShield Healthchoice	$205.00	$410.00	$369.00	$615.00	$335.83	$671.66	$604.49	$1,007.49
HIP Health Plan of New York	$211.51	$444.18	$370.15	$609.59	$274.38	$548.76	na	na
Horizon Healthcare of New York	$200.70	$401.40	$361.26	$609.27	$656.06	na	na	na
MagnaHealth of New York	$214.14	$428.29	$408.64	$644.39	$304.85	$609.70	$533.49	$914.55
Managed Health	$216.93	$433.64	$383.75	$644.28	$319.22	$638.10	$564.69	$948.05
MDNY Healthcare	$184.23	$381.73	$349.49	$553.06	$350.01	$700.02	$595.02	$1,015.03
Oxford Health Plans	$222.05	$488.50	$421.89	$703.89	$317.06	$634.12	$618.27	$951.18
Physician Health Services of New York	$222.91	$490.41	$412.39	$668.73	$344.92	$689.86	$624.61	$969.53
Aetna U.S. Healthcare	$205.80	$411.80	$363.60	$608.20	$313.80	$627.60	$555.40	$932.60
UnitedHealthcare of New York	$227.41	$474.15	$388.19	$679.27	$347.26	$694.52	$678.55	$1,031.36
Vytra Health Plans	$164.28	$368.32	$296.69	$479.04	$342.98	$685.98	$619.43	$1,000.15
Westchester County								
CIGNA Healthcare of New York	$213.33	$426.66	$395.13	$631.56	$367.01	$734.03	$623.92	$1,101.04
Empire BlueCross BlueShield Healthchoice	$205.00	$410.00	$369.00	$615.00	$335.83	$671.66	$604.49	$1,007.49
GHI HMO Select	$196.46	$437.01	$373.28	$572.25	$455.51	na	na	$1,161.57
HIP Health Plan of New York	$211.51	$444.18	$370.15	$609.59	$274.38	$748.76	na	na
Horizon Healthcare of New York	$200.70	$401.40	$361.26	$609.27	$519.50	na	na	$1,454.60
MagnaHealth of New York	$214.14	$428.29	$408.64	$644.39	$304.85	$609.70	$533.49	$914.55
Oxford Health Plans NY	$222.05	$488.50	$421.89	$703.89	$317.06	$634.12	$618.27	$951.18
Physician Health Services of New York	$262.15	$576.72	$484.97	$786.44	$368.59	$737.20	$667.47	$1,036.06
Aetna U.S. Healthcare	$205.80	$411.80	$363.60	$608.20	$313.80	$627.60	$555.40	$932.60
UnitedHealthcare of New York	$227.41	$474.15	$388.19	$679.27	$347.26	$694.52	$678.55	$1,031.36

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**Table 5. Healthy New York Premiums as a Percent of Individual Market Premiums
for HMO Policies, by HMOs in Seven Counties, February 2001**

	Policy Tier			
	Individual	Couple	Adult and Child	Family
Albany County				
Capital District Physicians' Health Plan	0.529	na	na	0.540
Empire BlueCross BlueShield Healthchoice	0.720	0.720	0.720	0.720
GHI HMO Select	0.448	na	na	0.512
Healthnow New York	0.416	na	na	0.455
MVP Health Plan	0.309	0.309	0.367	0.332
Cayuga County				
Excellus	0.627	na	na	0.755
Aetna U.S. Healthcare	0.656	0.656	0.655	0.652
UnitedHealthcare of Upstate New York	0.690	na	na	0.705
Univera Healthcare - CNY	0.633	na	na	0.657
Genesee County				
Excellus	0.657	0.810	na	0.580
Healthnow New York	0.461	na	na	0.526
Independent Health Association	0.564	na	na	0.600
Univera Southern Tier	0.524	0.545	na	0.524
Preferred Care	0.680	0.888	na	0.784
Univera Healthcare - WNY	0.522	0.560	0.541	0.517
New York County (Manhattan)				
Atlantis Health Plan	0.533	0.533	0.533	0.533
CIGNA Healthcare of New York	0.581	0.581	0.633	0.574
Empire BlueCross BlueShield Healthchoice	0.610	0.610	0.610	0.610
GHI HMO Select	0.431	na	na	0.493
HIP Health Plan of New York	0.771	0.809	na	na
Horizon Healthcare of New York	0.306	na	na	0.332
MagnaHealth of New York	0.702	0.702	0.766	0.704
Managed Health	0.618	0.618	0.618	0.618
MetroPlus	0.655	0.658	0.642	0.649
Oxford Health Plans NY	0.700	0.770	0.682	0.740
Physician Health Services of New York	0.615	0.677	0.629	0.657
Aetna U.S. Healthcare	0.656	0.656	0.655	0.652
UnitedHealthcare of New York	0.655	0.683	0.572	0.659

	Policy Tier			
	Individual	Couple	Adult and Child	Family
Orange County				
Capital District Physicians' Health Plan	0.517	na	na	0.527
CIGNA Healthcare of New York	0.581	0.581	0.633	0.574
Empire BlueCross BlueShield Healthchoice	0.600	0.601	0.600	0.600
GHI HMO Select	0.440	na	na	0.503
HIP Health Plan of New York	0.771	0.809	na	na
Horizon Healthcare of New York	0.386	na	na	0.419
MVP Health Plan	0.338	0.338	0.402	0.363
Oxford Health Plans NY	0.700	0.770	0.682	0.740
Physician Health Services of New York	0.719	0.791	0.735	0.768
Aetna U.S. Healthcare	0.656	0.656	0.655	0.652
UnitedHealthcare of New York	0.685	0.714	0.598	0.689
Suffolk County				
CIGNA Healthcare of New York	0.581	0.581	0.633	0.574
Empire BlueCross BlueShield Healthchoice	0.610	0.610	0.610	0.610
HIP Health Plan of New York	0.771	0.809	na	na
Horizon Healthcare of New York	0.306	na	na	0.332
MagnaHealth of New York	0.702	0.702	0.766	0.705
Managed Health	0.680	0.680	0.680	0.680
MDNY Healthcare	0.526	0.545	0.587	0.545
Oxford Health Plans	0.700	0.770	0.682	0.740
Physician Health Services of New York	0.646	0.711	0.660	0.690
Aetna U.S. Healthcare	0.656	0.656	0.655	0.652
UnitedHealthcare of New York	0.655	0.683	0.572	0.659
Vytra Health Plans	0.479	0.537	0.479	0.479
Westchester County				
CIGNA Healthcare of New York	0.581	0.581	0.633	0.574
Empire BlueCross BlueShield Healthchoice	0.610	0.610	0.610	0.610
GHI HMO Select	0.431	na	na	0.493
HIP Health Plan of New York	0.771	0.593	na	na
Horizon Healthcare of New York	0.386	na	na	0.419
MagnaHealth of New York	0.702	0.702	0.766	0.705
Oxford Health Plans NY	0.700	0.770	0.682	0.740
Physician Health Services of New York	0.711	0.782	0.727	0.759
Aetna U.S. Healthcare	0.656	0.656	0.655	0.652
UnitedHealthcare of New York	0.655	0.683	0.572	0.659

Table 6. For Qualified Individuals in Healthy New York:
Premium Costs as a Percent of Income, Using Lowest Premiums for Plan Type in Each County,
by Selected Counties and Assuming Entire Family Is Covered

Family Income	Plan Type and Family Size			
	Single–1	H/W Couple–2	Adult and Children–3	Family–4
Albany County				
Poverty	21.3%	31.4%	21.8%	28.1%
150%	14.2	21.0	14.5	18.7
200%	10.6	15.7	10.9	14.1
250%	8.5	12.6	8.7	11.3
Cayuga County				
Poverty	26.0%	38.4%	25.2%	35.3%
150%	17.3	25.6	16.8	23.6
200%	13.0	19.2	12.6	17.7
250%	10.4	15.4	10.1	14.1
Genesee County				
Poverty	16.8%	25.5%	19.7%	25.2%
150%	11.2	17.0	13.1	16.8
200%	8.4	12.7	9.9	12.6
250%	6.7	10.2	7.9	10.1
New York County (Manhattan)				
Poverty	27.2%	40.1%	29.7%	39.0%
150%	18.1	26.8	19.8	26.0
200%	13.6	20.1	14.9	19.5
250%	10.9	16.1	11.9	15.6
Orange County				
Poverty	24.6%	36.3%	25.7%	33.2%
150%	16.4	24.2	17.1	22.1
200%	12.3	18.2	12.9	16.6
250%	9.8	14.5	10.3	13.3
Suffolk County				
Poverty	23.1%	38.2%	24.4%	32.7%
150%	15.4	25.5	16.3	21.8
200%	11.5	19.1	12.2	16.3
250%	9.2	15.3	9.8	13.1
Westchester County				
Poverty	27.6%	41.6%	29.7%	39.0%
150%	18.4	27.8	19.8	26.0
200%	13.8	20.8	14.9	19.5
250%	11.0	16.7	11.9	15.6

Table 7. For Qualified Individuals in Healthy New York:
Premium Costs as a Percent of Income, Using Lowest Individual Premium in Each County,
by Selected Counties and Assuming Only One Person in Family Is Covered

Family Income	Family Size			
	1	2	3	4
Albany County				
Poverty	21.3%	15.7%	12.5%	10.3%
150%	14.2	10.5	8.3	6.9
200%	10.6	7.9	6.2	5.2
250%	8.5	6.3	5.0	4.1
Cayuga County				
Poverty	26.0%	19.2%	15.2%	12.6%
150%	17.3	12.8	10.2	8.4
200%	13.0	9.6	7.6	6.3
250%	10.4	7.7	6.1	5.1
Genesee County				
Poverty	16.8%	12.4%	9.9%	8.2%
150%	11.2	8.3	6.6	5.4
200%	8.4	6.2	4.9	4.1
250%	6.7	5.0	3.9	3.3
New York County (Manhattan)				
Poverty	27.2%	20.1%	15.9%	13.2%
150%	18.1	13.4	10.6	8.8
200%	13.6	10.0	8.0	6.6
250%	10.9	8.0	6.4	5.3
Orange County				
Poverty	24.6%	18.2%	14.4%	11.9%
150%	16.4	12.1	9.6	8.0
200%	12.3	9.1	7.2	6.0
250%	9.8	7.3	5.8	4.8
Suffolk County				
Poverty	23.1%	17.0%	13.5%	11.2%
150%	15.4	11.4	9.0	7.5
200%	11.5	8.5	6.8	5.6
250%	9.2	6.8	5.4	4.5
Westchester County				
Poverty	27.6%	20.4%	16.2%	13.4%
150%	18.4	13.6	10.8	8.9
200%	13.8	10.2	8.1	6.7
250%	11.0	8.2	6.5	5.4

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APPENDIX. THE DEMAND FOR SUBSIDIZED INSURANCE

This Appendix is a more detailed version of the text in Section III of the main report. We begin by defining and discussing the meaning of elasticity estimates. Next, elasticity of demand in the nongroup market is presented, followed by a discussion of elasticity of demand by firms and by firm employees. The section concludes with an assessment of the literature on the effects of subsidy programs in the context of Healthy New York.

Elasticity defined. Elasticity is defined as the percent change in the number of individuals purchasing/taking up insurance coverage, divided by the percent change in price of insurance (elasticity of demand) or the percent change in income (income elasticity). Elasticity of demand is always negative for normal goods, that is, as price increases, the quantity demanded decreases.

Identifying what people really "see" as the price can be difficult. For individuals in the nongroup market, the price of insurance is the premium paid by an individual.[26] For firms, the price is captured by a measure of premiums charged, typically with separate tiers for single and family coverage. For take-up by workers in firms, some studies use the full premium, while others use the share of the premium paid directly by workers.

Calculating and interpreting elasticity of demand. Elasticity of demand is defined as the percent change in quantity demanded in response to the percent change in price. Formulaically, elasticity is

$$\frac{\text{\% change in quantity}}{\text{\% change in price}} = \frac{\text{change in quantity/quantity}}{\text{change in price/price}} = \frac{(Q_2 - Q_1)/Q_1}{(P_2 - P_1)/P_1}$$

For example, suppose that health insurance premiums rise from \$100 to \$110. The percent change in price is \$110 – \$100/\$100, which equals 0.10 or 10 percent. Suppose further that, as a result of the price increase, the number of people covered drops from 1,050 to 1,000, a 5 percent decrease (1,000 – 1,050/1,000 = –0.05). Thus the elasticity calculation is –0.05/0.10, or –0.5. The elasticity means that for every 1 percent increase in price, coverage will decline by 0.5 percent. It can also be stated that for every 10 percent increase in premiums, coverage will decline by 5 percent. Because of the way that they are

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[26] Economic theory holds that the "price" of insurance is only the loading charge imposed by the insurance carrier, since a person is already at risk for the expected health costs whether insured or uninsured. Thus, the theoretical price of insurance is the difference between the premium and the person's expected health costs.

estimated, elasticities are valid for price changes close to the original price, but they lose meaning as the price change becomes very large. Elasticity estimates can also be used in combination with individual or firm level data to derive estimates of the effects of premium changes on participation.

Study design is an important consideration in assessing which estimates are most rigorous. To develop estimates of elasticities, researchers identify a source of variation in premium prices (such as regional differences or changes to the tax code) or income levels that is then used to estimate how people respond. However, even among the most rigorous studies, the study population and the costs of premiums will influence how generalizable the results are to the population characteristics and insurance market in New York State. Furthermore, analyses of pilot subsidy projects showed low response to reductions in price, most likely due to the perception that the programs were temporary in nature (see Thorpe et al. 1992). Thus, the results in the literature are helpful in establishing reference points for assessing the probable response to the Healthy New York program, but will not apply exactly to the current program. The results of studies discussed in this section present information on the study design, population characteristics, and premium levels (for elasticity of demand) to contextualize study results, and the demonstration findings are discussed in more detail below.

Estimates of Price and Income Elasticity in the Nongroup Market
In 1997, 4.1 percent of residents of New York State held individual coverage, compared with 5.3 percent of the nonelderly nationally (Thorpe 1999). Individual coverage has declined since 1994 in New York, more so than nationally (1.5 versus 0.3 percentage points). Declines in this period have occurred primarily among single individuals and two adult households as opposed to households with children, and among noncitizens as opposed to citizens. Individuals with income below poverty or from 100 to 200 percent of the poverty level are more likely to purchase individual coverage than those with higher incomes; however, rates of individual coverage among low-income populations in New York are lower than rates in the United States overall.

Overall, results from the literature suggest that price elasticities in the individual market are relatively inelastic, though low-income people have slightly more price elastic demand. These results strongly suggest that even relatively large subsidies will have limited results on coverage levels.

Swartz (1988) estimates elasticity of demand for self-pay (nongroup) health insurance policies for nonelderly adults who are single or a head of household, with

nongroup coverage or who are uninsured. Data analyzed are from the March 1984 Current Population Survey for individual characteristics and national Blue Cross Blue Shield premium data for standard self-pay policies. 1984 average annual premium costs for a single male in Maryland are $489, and for a married couple are $1,078. Premiums are assigned based on Blue Cross Blue Shield criteria to individuals based on their characteristics. The elasticity estimates are derived by constructing a demand function by using the probabilities of participation at various premium levels. Swartz estimates price elasticity for a single man at –0.108, and a married man at –0.097. A 75 percent subsidy increases the number purchasing self-pay by only 13 percent.

Marquis and Long (1995) also focus on demand for nongroup coverage among families with one employed head and without employment-based health insurance, Medicare, or Medicaid. They rely on data from the May and March 1988 CPS for information on coverage and employer offers, the 1987 panel of the SIPP (sixth interview) for health status, and 1989 premiums data from Celtic Life Insurance Company. Premium data are average offer prices for an MSA, CMSA, or non-metropolitan area, linked to families by location of residence (the New York metropolitan area is excluded from this analysis because these data do not include premiums for New York City). The average (mean) annual premium cost for a single male in the CPS sample is $910, with a range from $680 to $4,347. Price elasticities are estimated for families with income above and below 200 percent of poverty for all families and for families not offered health insurance. The results suggest that low-income families are slightly more sensitive to price than higher income families. For income below 200 percent of poverty, elasticity estimates are –0.3 to –0.4, while for income above 200 percent estimates are from –0.27 to –0.33. Estimates for families not offered insurance suggest that these families are still more responsive to price, at –0.64 for low-income families and –0.54 for higher income families. Based on these results, a 60 percent subsidy would increase participation to about 50 to 60 percent from 40 percent participation with no subsidy, and would reduce the number of uninsured families by 16 percent.

Several recent analyses of tax credit proposals also provide insight into price elasticity and participation estimates. Gruber (2000), in an analysis of effects of tax subsidies for insurance on coverage rates, relies on an elasticity of –0.625 (based on published estimates) for take-up of subsidized nongroup health insurance among those who are uninsured. This elasticity estimate is adjusted for premiums relative to income to account for differences in demand for insurance by income level. The results of Gruber's analysis are affected by the elasticity estimate: using –0.4 instead of –0.625 for take-up of nongroup insurance among previously uninsured in response to a $1,000 single or $2,000

family credit shows a large reduction in the number of newly insured (1.5 million fewer people).

Feder et al. (1999) estimate take-up rates for programs (multiple types, not specified which here) of various subsidy levels among individuals and families at three income levels. Among individuals with incomes below 150 percent of poverty, from 150 to 250 percent of poverty, and above 250 percent of poverty whose premium cost would represent 20 percent or more of income, but for whom premiums are completely subsidized (free), insurance participation rates would be 72 percent, 77 percent, and 84 percent, respectively. However, if these same individuals instead faced a premium requirement of less than 2 percent of income, as opposed to a full subsidy, participation rates drop dramatically to 31, 36, and 44 percent, respectively, in the three income groups.

Price Elasticity: Firms and Workers' Demand for Employment-Based Insurance
In New York State, half of all uninsured workers are in firms with fewer than 25 employees, and two-thirds work in firms with fewer than 100 employees (United Hospital Fund 2000). Overall, 89 percent of uninsured workers are in firms that do not offer coverage (75%) or in which they are not eligible for coverage (14%) (United Hospital Fund 2000).

Small firms face significant challenges in securing affordable health insurance coverage for their workers. Small firms face higher loading costs from insurers due to higher administrative costs for smaller groups of workers, contributing to lower rates of coverage in small versus large firms. Also, small firms are less able to switch coverage in response to high health insurance premiums, resulting in less competitive markets (Cutler 1994). Furthermore, Cutler finds a large variation in premiums for small firms: premiums at the 90th percentile are 2.5 times those at the 10th percentile of the distribution. Many small firms are relatively new businesses, while the likelihood of firms offering insurance increases with the number of years a firm has been operating (Shore-Sheppard et al. 2000).[27] Despite public policy efforts to address these problems, the empirical literature thus far shows no effects of legislative changes on small firm offer rates (Jensen and Morrisey 1999) or premium variability (Cutler 1994).

Overall, trends in employment-based coverage spanning the late 1980s to the late 1990s show that coverage levels have declined despite increases in coverage offer rates. Instead, this decline has occurred because employee take-up rates have fallen (Cooper and

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[27] Specifically, Shore-Sheppard et al. find that the probability of offering insurance increases by one percentage point for every 3 to 5 years a firm has been operating.

Schone 1997; Farber and Levy 2000). Among low-income or less-educated workers, however, declines are due to reductions in offer as well as take-up rates. Thus, an understanding of both elasticity of demand for offer and the employee's elasticity of demand for take-up is necessary in order to assess potential effects of firm premium subsidies on coverage levels.

When considering price and income elasticity among firms and employees, three aspects must be considered. First is the elasticity of demand by the firm to *offer* health insurance, which is calculated based on the full price of the premium. This may differ by firm size, as some results below suggest. Second is the elasticity of take-up of health insurance by employees among firms that offer insurance. Even in the event that firms offer coverage, the relevant question for determining the impact on coverage rates is whether employees choose to take up offered coverage. Elasticity of take-up may be calculated based on the full premium cost (reflecting economic theory that workers pay for health insurance through reduced wages) or based on the share of the premium paid by employees (reflecting that employees may perceive their contribution as the cost of health insurance). Third, in calculating price and income elasticity a question arises as to which employees are considered as representative for the firm. One theory is that decisions about insurance offering are made based on the "median" worker. The idea behind this model is that the person in the middle is the "tiebreaker" in a decision about whether to offer a benefit. However, it is also possible that a firm with mostly low-income workers, but with several very highly paid workers would make decisions reflecting the preferences of the higher-income workers. This type of decision-making would be captured by an "average" worker model. One or more of these distinctions are addressed in the studies reviewed below.

Gruber and Lettau (2000) estimate elasticity of offer for after-tax price to the median worker in a firm relying on data from the Employment Compensation Survey, 1983 to 1993, matched to CPS and Statistics of Income data on workers' tax subsidy levels. The data are restricted to full-time jobs in order to focus on eligible workers. The average cost for insurance premiums is $2,223 in 1993 dollars. Gruber and Lettau estimate elasticity of offer by determining how variation in the after-tax price of insurance for workers of different income levels affects the probability of a firm offering insurance. They find the firm elasticity of offer of –0.32. Furthermore, looking specifically by firm size, the results show that responsiveness of offer is greater for small firms: –0.68 for firms <100 employees versus –0.12 for medium size firms (elasticity cannot be estimated for large firms because nearly all offer insurance).

Gruber and Lettau also investigate how firms "aggregate" worker preferences for insurance. Comparing the tax prices of insurance for the "median" worker (the person in the middle of the income distribution) and the average worker (which will reflect whether income is more skewed toward high or low end of the spectrum), the results show that the median worker model better describes benefit provision than average tax prices. However, there is indication that the standard deviation of tax prices matters as well, potentially driven by tastes of highest-paid workers for offering.

Shore-Sheppard et al. (2000) model the probability that a firm will offer health insurance using establishment data from surveys of firms with from 5 to 100 employees sponsored by HIAA and KPMG Peat Marwick/Wayne State University. Elasticity is estimated from a regression of employer offer on firm and market characteristics and Medicaid eligibility of employees. The results show that firms with more low wage workers are less likely to offer insurance: a 10 percentage point increase in workers earning less than $10,000 per year lowers the probability of offer by 5 percentage points. This results in a firm weighted elasticity of –.15, employee weighted elasticity of –0.12.

In addition, this study estimates elasticity of take-up among employees in firms. A multivariate analysis of the effect of employee premium contribution levels on take-up rates shows that a $10 increase in monthly premium contributions leads to a 1.5 percentage point decrease in participation rates, which translates to an elasticity of take-up of –0.045. The results furthermore indicate that take-up rates are lower in firms with a larger share of low-income employees. A 10 percent increase in the share of employees with income below $10,000 results in a 2.2 percentage point decline in the share of employees taking up coverage.

Monheit and Schone (2000) analyze the nationally representative 1996 MEPS, household component and insurance component to estimate elasticities of demand for employment-based health insurance for low-wage (below $7.00/hour, mean family income in 1996 $34,837) and higher-wage (> $7.00/hour., mean family income $57,432) workers ages 21 to 64. Premium costs are assigned to each worker, based on the average premium for single workers in the same state and firm size. Elasticities of take-up and overall coverage are estimated based on simulated responses to a 10 percent increase in premium costs. The results show that low-wage workers are more responsive to premium increases than workers overall. Specifically, Monheit and Schone estimate a participation elasticity of –0.65 for low-wage worker take-up and an elasticity of coverage of –0.70 for low-wage workers, while for workers overall the estimates are –0.03 for take-up and –0.14 for coverage, respectively. These results are based only on cross-sectional estimates, however.

Long and Marquis (1999) analyze employees' take-up rates when employers contribute varying levels of the premium. They rely on the 1993 National Employer Health Insurance Survey (CDC/NCHS) and 1997 RWJF Employer Health Insurance Survey to construct a multivariate model of family coverage enrollment rates as a function of employer contribution levels to single and family coverage, firm and employee characteristics, and whether there is choice of plans and type of plans offered. Descriptive analysis shows that employees are less likely to elect family coverage when the employer contributes a lower share of the premium. Employees are less likely to elect family coverage if the employer contributes a lower versus higher share of the premium. Forty-two percent of employees with a contribution below 60 percent elected family coverage, compared to 55 percent with a premium contribution from 60 to 79 percent or a contribution of 80 percent or above. Modeling the effects of changes to employer contribution levels indicates that a 20 percent reduction in contribution would result in only a 2 percentage point reduction in family enrollment (from 51.7% to 50.0%), holding single contributions constant.

Blumberg, Nichols, and Liska (1999) estimate elasticity of demand by firms with a data set they create to estimate responses of firms to proposed legislation that would create new pooling options (Association Health Plans and HealthMarts). The model is created by combining data from the 1993 Current Population Survey Employee Benefit Supplement for individual level characteristics and the 1987 National Medical Expenditure Survey for expenditures, which are adjusted based on a standardized benefit package, and RWJF 1993 Employer Health Insurance Survey data to estimate firm offer. Average premiums are estimated at $2,000 for a single and $5,100 for a family. To estimate elasticity, the authors' first estimate probability of offer not including premiums, then build from those results estimates of premiums for firms that offer and those that do not offer insurance, then estimate probability of offering insurance based on the estimated premiums as well as firm and individual characteristics. The model is based on the Feldman et al. (1997) approach, discussed below, with several modifications. Blumberg et al.'s results indicate that elasticity is greatest in firms that are smallest, with results of –1.53 for single and –1.49 for family policies in firms with fewer than 10 employees, in contrast to elasticity of –0.31 single and –0.29 family for large firms (> 500 employees).

Feldman et al. (1997) estimate elasticity of demand for insurance for small firms (< 50 employees) that do and do not offer coverage. They analyze data on 2,000 small firms in Minnesota, a component of the full 1993 RWJF EHIS. Analysis proceeds in several steps. First, Feldman et al. estimate reduced form equations to estimate offer likelihood. Next, they estimate premiums, correcting for selection (i.e., premiums only

available for firms that offer insurance). For a policy with a $1,000 deductible and 50 percent coinsurance, predicted single premiums were $95.83 for firms that offered, and $105.25 for those that did not, and family were $217.74 and $271.17, respectively. Feldman et al. find that, at the mean of the data, elasticity of demand is –3.9 for single and –5.8 for family coverage.

Baumgardner and Hagen (2000) estimated the effects of legislation that would create Association Health Plans and HealthMarts on premium costs and coverage for small firms with fewer than 50 employees. Using data from the 1996 MEPS IC, they estimate that the average premium for participating small firms would decrease by 13 percent. To predict the effect on coverage, they rely on an estimate of elasticity of demand for insurance for small firms of –1.1, noting that this estimate is higher than many in the literature but consistent with estimates that find higher elasticity for small firms (Feldman et al. 1997; Blumberg et al. 1999). Overall they predict that coverage in small firms would increase by 1.3 percent, or 330,000 people nationally, as a response to the proposed legislation.

Results from Evaluations of Prior State Subsidy Programs

One lesson from past work on elasticity of offer by firms from demonstration programs is that participation may be lower than many elasticity estimates would suggest. A review of prior literature on elasticity of demand (Gruber and Lettau 2000) reveals the lowest estimate of elasticity of offer, –0.07 (Thorpe et al. 1992), was derived from an analysis of response to a pilot project initiated by New York State in 1989. A subsidy of 50 percent of the premium led to at most a 3.5 percentage point increase in the number of firms offering insurance (Thorpe et al. 1992). A major conclusion made by the authors is that the results, which show nearly perfectly inelastic demand (i.e., no response to price reductions), may in fact reflect an unwillingness on the part of small firms to participate in a program that was perceived as being of limited duration or may reflect limited awareness of these programs by small employers (Thorpe et al. 1992; see also Morrisey, Jensen, and Morlock 1994).

In the individual market, analysis of New Jersey's subsidy program also suggests that higher levels of subsidy are more effective at enrolling eligible people. Swartz and Garnick (2000b) show that in New Jersey's subsidy program for the low-income (<250% of poverty) uninsured, more people at the lower end of the income eligibility cutoff participated in the program, reflecting a higher subsidy for those of lowest incomes. For example, at income below 100 percent of poverty and at 250 percent of poverty, the required premiums for the lowest cost single policies constitute 0.8 percent and 10.9

percent of family income, respectively, and 0.8 percent and 10.05 percent for a family policy for 2 adults and 2 children. Enrollees to the program were overwhelmingly lower income: 49 percent had income below the poverty level and another third (32%) had income from 100 to 150 percent of poverty. Furthermore, enrollees chose the lowest cost plans: roughly 50 percent chose lowest cost and 75 percent chose one of the two lowest cost plans. While insufficient data were available to estimate a price elasticity of demand, these results illustrate the practical effects of designing a premium subsidy program to most heavily subsidize those of lowest incomes.

Ku and Coughlin (1999/2000) pool data from insurance programs in Washington (state-run expansion), Minnesota (state and Medicaid expansion), and Hawaii (Medicaid expansion). Experience in these programs shows that participation rates fall as premiums increase: as premiums increase from 1 percent to 3 percent of family income, expected participation rates fall from 57 percent to 35 percent and at 5 percent of income, to 18 percent participation. The results also indicate that many would not participate even if insurance were free, while some will participate at relatively high premiums. These results are not based on subsidy programs, but rather on state expansions of public programs, however. Furthermore, Haslanger et al. (1998) report an analysis by Thorpe (1997) which concludes that participation rates drop from 75 percent in a free plan to 40 percent with a contribution requirement that amounts to 6 to 10 percent of income.

Finally, two case studies point to operational aspects of premium charges and enrollment levels, noting that failure to pay premiums is a main reason for disenrollment. Summer (1998) presents this finding for disenrollment from state subsidized insurance programs, acknowledging that it is not known whether inability to pay or no longer wanting to be enrolled is the reason. O'Brien et al. (2000) note that for child health insurance expansions, California data show that 2.6 percent of enrollees disenrolled from July 1998 to May 1999; of these, 46.4 percent due to failure to pay premiums (n=1,511), while in Washington state, a 62 percent premium increase was followed by a 40 percent drop in enrollment, with 72 percent citing cost as the reason.

Summary

Overall, results from the literature strongly suggest that a relatively small reduction in premium costs is not likely to produce much of a demand response from individuals and firms, or much employee take-up. In addition, marketing of program and long-term state commitment is a necessary component to encourage participation by small firms. While the empirical results provide indications of what to expect, the actual experience with Healthy New York may differ, as the health insurance market in New York may differ

from the market in other studies (due to factors such as premium costs, the high immigrant population, etc.). The program may nonetheless have a stabilizing effect on coverage for vulnerable uninsured populations in New York, thus fulfilling one of the goals of the legislation.

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Accessibility of Primary Care Services in Safety Net Clinics in New York City (August 2001). Eve Weiss, Kathryn Haslanger, and Joel C. Cantor. *American Journal of Public Health,* vol. 91, no. 8. Copies are available from Kathryn Haslanger, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399, E-mail: khaslanger@uhfnyc.org.

#458 *Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State* (March 2001). Deborah Bachrach, Karen Lipson, and Anthony Tassi, Kalkines, Arky, Zall & Bernstein, LLP. This study of health insurance coverage among New York State's legal immigrants finds that nearly 170,000 low-income adults who would otherwise be eligible for public insurance programs are denied coverage solely because of their immigration status.

Medicaid Managed Care in New York City: Recent Performance and Coming Challenges (March 2001). Derek DeLia, Joel C. Cantor, and David Sandman. *American Journal of Public Health,* vol. 91, no. 3. Copies are available from Derek DeLia, United Hospital Fund, 350 Fifth Avenue, 23rd Floor, New York, NY 10118-2399, E-mail: ddelia@uhfnyc.org.

#444 *Creating a Seamless Health Insurance System for New York's Children* (January 2001). Melinda Dutton, Kimberley Chin, and Cheryl Hunter-Grant, Children's Defense Fund–New York. New York has recently brought Medicaid and Child Health Plus together, making the two programs more compatible. This paper takes a comprehensive look at both these programs in order to identify areas of continued programmatic disparity and explore ways to bridge differences.

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#372 *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus* (March 2000). Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#369 *Five Boroughs, Common Problems: Health Care in New York City* (February 2000). David Sandman and Elisabeth Simantov. This fact sheet summarizes, by New York City borough, the number of uninsured, the rates of Medicaid coverage, demographic characteristics, and access to health care.

Preventive Service Use and Medicaid Managed Care in New York City (January 2000). Anne Reisinger and Jane Sisk. *American Journal of Managed Care,* vol. 6, no. 1. Copies are available from *American Journal of Managed Care,* American Medical Publishing, 241 Forsgate Drive, Suite 102, Jamesburg, NJ 08831, Phone: 732-656-1006, Fax: 732-656-0818, www.ajmc.com.

#349 *Health Care in New York City: Understanding and Shaping Change* (September 1999). David R. Sandman. This issue brief highlights Fund programs that have been implemented to protect health care access for New York City residents—especially its low-income citizens—in the face of rising uninsurance, the move to mandatory Medicaid managed care enrollment, and the increasing strain on the city's safety net providers and academic health centers.

#340 *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (July 1999). Jocelyn Guyer and Cindy Mann, Center on Budget and Policy Priorities. The authors show how New York could make a substantial dent in its number of uninsured working adults if it took advantage of a little-known legislative opportunity and raised the income eligibility level for subsidized health insurance.

#305 *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus* (December 1998). Peter Feld, Courtney Matlock, and David R. Sandman. This qualitative study sheds light on why a large majority of New York City children who are eligible for Medicaid and New York State's Child Health Plus (CHP) program remain uninsured, even as the state is set to expand coverage to many more low-income families. The report reveals that parents face serious obstacles to getting their children on Medicaid and keeping them on, and have minimal awareness of CHP.

#274 *New York City's Children: Uninsured and at Risk* (May 1998). Cathy Schoen and Catherine DesRoches. This report, based on *The Commonwealth Fund Survey of Health Care in New York City,* finds that children living in New York City are more likely to be uninsured than children in other areas, and that children in low-wage working families are particularly at risk.

#264 *The Commonwealth Fund Survey of Health Care in New York City* (March 1998). David R. Sandman, Cathy Schoen, Catherine DesRoches, and Meron Makonnen. This survey of more than 4,000 New York City residents, conducted by Louis Harris and Associates, Inc., found that a New Yorker was 50 percent more likely to be uninsured than the average American, that the vast majority of the City's uninsured live in working families and have low incomes, and that the City's public hospitals, emergency rooms, and clinics provide an important safety net for the uninsured.