The LEWIN GROUP

Estimates of the Cost and Coverage Impacts of Proposals to Expand Health Insurance Coverage in New York

Final Report

Prepared For:

**The United Hospital Fund and
The Commonwealth Fund**

December 14, 2006

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COVERAGE EXPANSIONS OPTIONS

In this report, we present estimates of the cost and coverage impacts of six proposals to expand health insurance coverage in New York. All of these proposals adopt several policies designed to increase coverage among uninsured people who are eligible for but not enrolled in the existing Medicaid and State Children's Health Insurance Program (SCHIP) programs. These proposals would also increase income eligibility for childless adults from its current level of 100 percent of the federal poverty level (FPL) to 150 percent of the FPL, and create a subsidized Medicaid buy-in program for others living below 300 percent of the FPL.

We estimated the impact of these proposals with and without a mandate for people to have health insurance coverage. In addition, we analyzed the impact of combining these policies with a "pay-or-play" requirement for employers that levies a tax on employers who do not offer health insurance. These policy scenarios include:

- **Individual voluntary coverage scenario:** This scenario includes administrative simplification for Medicaid and SCHIP together with the expansion in eligibility for childless adults and the Medicaid buy in program;

- **Individual mandatory coverage scenario:** This scenario requires all New York residents to have insurance. It also includes the same administrative simplification, eligibility expansion and buy-in program provisions under the first scenario;

- **Pay-or-Play without a mandate for coverage:** Under this scenario employers are required to either provide health insurance coverage or pay a tax equal to 8.0 percent of payroll which is used to fund the cost of increasing eligibility for childless adults and the subsidized buy-in program. However, under this scenario, we assume that people are not required to have insurance. It includes the same administrative simplification, eligibility expansion and buy-in program provisions under the first scenario;

- **Pay-or-Play with a coverage mandate:** This scenario combines the pay-or-play option with a mandate for individuals to have insurance coverage. This option also includes the same eligibility simplification and Medicaid eligibility expansions described in the prior scenarios;

- **Employer assessment with individual coverage assessment:** This option would require employers to pay an assessment of $400 for each full-time-equivalent (FTE) employee. Employers would pay an assessment of $400 per employee who is not eligible for a health insurance plan sponsored by the employer (e.g., workers in non-insuring firms and excluded workers in firms offering insurance). It includes the same administrative simplification, eligibility expansion and buy-in program provisions; and

- **Expansions in eligibility for the Healthy New York (HNY) program:** This option would increase eligibility for the HNY program from firms with 50 or fewer workers to 100 workers and eliminates the restriction to low-wage workers.

In addition, we include an analysis of the cost of covering all uninsured people who are eligible for but not enrolled in the Medicaid and SCHIP programs. *Appendix A* presents our analyses of options to increase Medicaid enrollment through administrative simplification. Appendix B presents the methodology used to simulate coverage expansion proposals. We present our

analyses of options to expand the HNY program in *Appendix C.* In *Appendix D*, we present estimates of the cost impacts on stakeholder groups under the four major policy proposals analyzed in this study. These include the individual coverage expansion scenarios and the pay-or-play scenarios, with and without a mandate for individuals to enroll.

I.   ANALYSIS OF THE INDIVIDUAL VOLUNTARY COVERAGE SCENARIO

In this scenario, we estimate the cost and coverage impacts of a voluntary coverage program. The provisions within this scenario include the Medicaid and FHP administrative simplifications, an increase in eligibility for childless adults to 150 percent of the FPL, and the FHP buy-in for people living between 150 percent and 300 percent of the FPL.

In this analysis, we first estimated the impact of increasing income eligibility for childless adults under FHP from its current level of 100 percent of the FPL to 150 percent of the FPL. We assume no premium payment and no waiting period for enrollment into this program. Federal funds would not be available for newly eligible childless adults. However, federal matching funds would be available for currently eligible but not enrolled childless adults who become enrolled through the spill-over effect. Total costs would be $1,020.3 million, of which the state share would be $862.9 million (*Figure 1*).

Figure 1
Estimated Impact of Increasing Family Health Plus Eligibility to
150 Percent of the FPL for Childless Adults [a/]

	Newly Enrolled				Costs for New Enrollees (millions)	Federal Share (millions)	State Share (millions)	PMPM
	Total Enrollment	Now with ESI	Now with Non-group	Reduction in Uninsured				
Increase FHP Eligibility for Childless Adults to 150 percent of the FPL								
Newly Eligible Adults	209,607	73,840	22,583	113,184	$717.6	--	$717.6	$285.31
Currently Eligible Adults "spillover effect"	114,240	9,425	4,855	99,960	$302.7	$157.4	$145.3	$220.80
Total Impact								
Total	323,847	83,265	27,430	213,144	$1,020.3	$157.4	$862.9	$262.55

a/ Assumes no waiting period for program enrollment.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Secondly, we analyzed the enrollment and costs of a subsidized Buy-in to FHP. Under this provision, families and childless adults living between 150 percent and 300 percent of the FPL would be permitted to buy-in to the FHP program. The program would have a premium based upon costs under the FHP program that would vary on a sliding scale with income. Benefits and co-payments would be same as under FHP. There is no waiting period where employers or individuals are required to have been without ESI for a specified number of months (e.g., six months).

The premium subsidies under this program have the effect of lowering the cost of insurance for affected people, which would induce many eligible individuals to take coverage. We simulated the buy-in under the following premium subsidy schedule.

Income as Percent of FPL	Subsidy
Less than <150% of FPL	100%
151-200% of FPL	80%
201-250% of FPL	65%
251-275% of FPL	50%
276-300% of FPL	25%

For these analyses, the following premiums were used for the FHP buy-in:

Person Age	PMPM
Children	$140
Parents	$258
Other Adults < age 30	$237
Other Adults age 30 & over	$347

We assume that the buy-in would be implemented together with the expansion in eligibility to 150 percent of the FPL for childless adults under FHP. *Figure 2* shows enrollment and costs under the FHP buy-in program.

Figure 2
Impact of a Subsidized FHP Buy-in for People Between 150 Percent and 300 Percent of the FPL under the Voluntary Coverage Scenario [a/]

	Newly Enrolled (1,000s)	Now with ESI (1,000s)	Now with Non-group (1,000s)	Net Impact on Uninsured [b/] (1,000s)	Program Costs (millions)	Subsidies (millions)
Children	190.9	128.8	8.2	46.8	$369	$275
Parents	466.3	314.8	15.6	117.8	$1,737	$1,312
Childless Adults	704.0	424.0	78.0	175.4	$3,017	$2,382
Total	1,361.4	866.6	101.7	340.0	$5,122	$3,968

a/ Does not include the cost of increasing FHP eligibility to 150 percent of the FPL for childless adults. These estimates include people enrolling in the buy-in due to discontinuations of employer coverage. These estimates assume no waiting period requirement.
b/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 3 shows the impact of implementing the administrative simplifications together with an increase in eligibility for childless adults to 150 percent of the FPL. Under this combined approach, enrollment would increase by a total of 768,400 people. The number of people without health insurance would be reduced by about 496,000. The program would cost about

$1.7 billion assuming full implementation in 2006. Federal matching funds would be available for newly enrolling people who are already eligible and those who become eligible with the elimination of the assets test, amounting to $529.3 million in 2006. The state share of costs would be about $1.2 billion.

Figure 3
Summary of the Cost and Coverage Impacts of Combining Various Approaches for Expanding Insurance Coverage in New York under the voluntary FHP buy-in Scenario [a/]

	Newly Enrolled (1,000s)	Net Reduction in Uninsured [b/] (1,000s)	Costs for New Enrollees [c/] (millions)	Federal Share (millions)	State Share (millions)
Combined Effects of Administrative Simplifications					
Children	262.5	175.2	$284.5	$150.4	$134.1
Adults	217.5	138.6	$526.1	$273.6	$252.5
Total	480.0	313.8	$810.6	$424.0	$386.6
Administrative Simplifications Combined with FHP Expansion to 150% of FPL for Childless Adults					
Children	262.5	175.2	$284.5	$150.4	$134.1
Adults	505.9	320.8	$1,403.2	$378.9	$1,024.3
Total	768.4	496.0	$1,687.7	$529.3	$1,158.4
Administrative Simplifications With FHP Expansion and Buy-in Through 300% of the FPL					
Children	453.4	222.7	$559.5	$222.6	$336.9
Adults	1,676.2	614.0	$5,097.2	$550.1	$4,547.1
Total	2,129.6	836.7	$5,656.7	$772.7	$4,884.0

a/ Figures may not sum to total due to overlapping effects of proposals. Includes new Benefits and administrative cost savings.
b/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage (52,000 people).
c/ Includes new benefits, administrative cost savings, and premium subsidy costs for the buy-in. Assumes no waiting period requirement.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

We also estimated the impact of implementing the FHP buy-in for people living between 150 percent and 300 percent of the FPL together with the administrative simplification, and eligibility expansion to 150 percent of the FPL for childless adults. Under this scenario, enrollment in Medicaid and SCHIP would increase by about 2.1 million people. The number of uninsured would decline by about 836,700 people, of whom 222,700 would be children. Total program costs, including premium subsidies under the buy-in, would be about $5.7 billion in 2006. The federal funds would be $772.7 million with the state paying about $4.9 billion.

Figures 4 and 5 show the transitions in coverage under the voluntary coverage proposal after all provisions are in place. Under the Buy-In program, we estimate that some workers and dependents (289,000) would drop their employer-sponsored coverage to enroll in the Buy-In because they would pay less for their share of the premium after subsidies and there is no

waiting period. We also estimate that some employers are likely to eliminate coverage because their workers on average would pay less under the public programs. We estimate about 980,000 workers and dependents would lose employer coverage. Of those losing coverage about 177,000 would be eligible for and enroll in Medicaid, 402,000 would purchase subsidized coverage through the Buy-In program, 350,000 purchase Buy-in coverage and 52,000 would become uninsured.

Figure 4
Coverage Transition by Provision under the Individual Voluntary Proposal (in 1,000s)

	Current Law	Administrative Simplification		Administrative Simplification + Expansion to 150%		Administrative Simplification + Expansion to 150% + FHP Buy-in	
		Number of People	Net change	Number of People	Net change	Number of People	Net Change
ESI	9,717	9,598	-119	9,517	-81	8,247	-1,270
Non-Group	469	422	- 47	397	-25	645	+248
Medicaid & FHP	3,546	4,026	+480	4,314	+288	4,491	+177
FHP Buy-In (150%-300%FPL)	0	0	0	0	0	1,185	+1,185
Uninsured [a]	2,805	2,491	-314	2,309	-182	1,969	-340
CHAMPUS	144	144	0	144	0	144	0
Medicare	2,405	2,405	0	2,405	0	2,405	0

a/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In (888,000 people) net of the increase in uninsured people due to employers dropping coverage (52,000 people).

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 5
Coverage Transitions under the Voluntary Coverage Proposal (in 1,000s)

Base Case Coverage	Total	Primary Source of Coverage Under Proposal							
		Buy-in 150%-300% FPL	Buy-in Over 300% FPL	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	9,717	691	350	8,247	0	0	0	377	52
Non-Group	469	102	0	0	295	0	0	72	0
CHAMPUS	144	0	0	0	0	144	0	0	0
Medicare (incl. Dual Eligible)	2,405	0	0	0	0	0	2,405	0	0
Medicaid (w/o Dual Eligible)	3,546	0	0	0	0	0	0	3,546	0
Uninsured	2,805	392	0	0	0	0	0	496	1,917
Total	**19,087**	**1,185**	**350**	**8,247**	**295**	**144**	**2,405**	**4,491**	**1,969**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 6 presents the net program costs (i.e., benefits and administrative costs less family premium contributions under the public plans) for the buy-in program. The table separates the costs for groups that will be eligible for federal matching funds. Overall these programs would cost the state about $4.1 billion in 2006. We estimate the state would save about $617 million from other safety net programs as previously uninsured people become covered.

Figure 6
Program Expenditures under Public Plans under the
Buy-In Program (in millions)

	Net Program /a	Federal	State d/
Public Program Costs			
Administrative Simplification	$970	$529	$440
Expansion to 150% FPL for Childless Adults	$718	--	$718
Buy-in Program Impacts			
Medicaid	$439	$243	$196
Sliding Scale Premium Buy-in to 300% FPL	$3,529	--	$3,529
Subsidy Administration /b	$142	--	$142
Healthy New York (HNY) /c	($66)	--	($66)
Primary Payer Payments	($215)		($215)
Safety Net Programs	($617)	--	($617)
Total Program Costs	**$4,900**	**$772**	**$4,128**

a/ Includes benefits and administrative costs for Medicaid and SCHIP and the premium subsidy costs for the buy-in program. Premium subsidies are 100% of premium for persons below 150% FPL, 80% of premium for persons 151-200% FPL, 65% of premium for persons 201-250% FPL, 50% for persons 251-275% FPL, and 25% for persons 276-300% FPL.
b/ Assumes eligibility determination expense of $171 per application, which is based on the average cost of eligibility determination in public programs in New York.
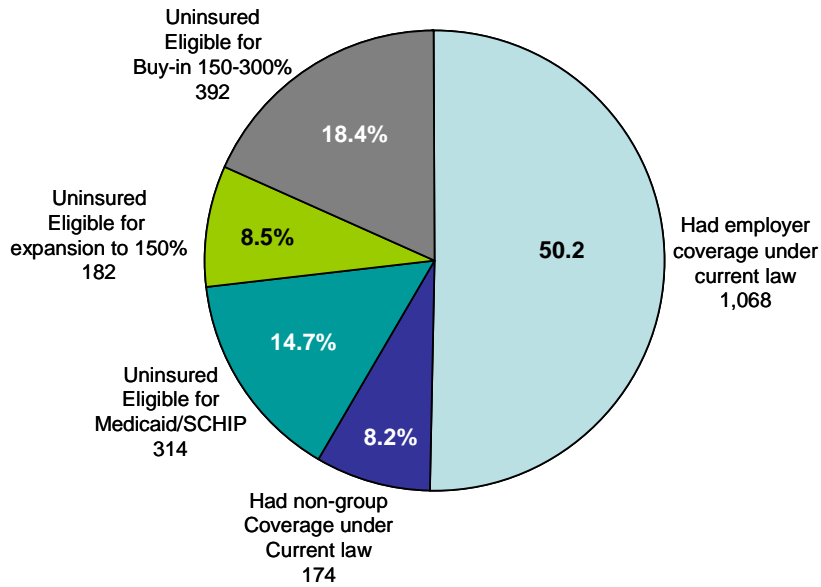c/ Savings to the state of reduced spending for HNY when the mandate is introduce. Estimates assume no change in HNY program eligibility.
d/ Does not include changes in tax revenues due to wage effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

About 2.1 million people would receive subsidized coverage under the combined programs (*Figure 7*). These include people enrolled through the administrative simplification, the FHP expansion to 150 percent of FPL for childless adults and the FHP buy-in for people between 150 and 300 percent of FPL. Of the 2.1 million receiving subsidized coverage, about 58 percent previously had private coverage from an employer (1.1 million) or non-group (174,000). The remaining 42 percent were previously uninsured. Of the previously uninsured, 314,000 were eligible for Medicaid/SCHIP, 182,000 were newly covered under the expansion to 150 percent of FPL for childless adults and 392,000 were newly covered under the expansion to 300 percent of FPL.

Figure 7
People Obtaining Subsidized Coverage under the Combined Policy (in 1,000s)

Uninsured Eligible for Buy-in 150-300% 392 — 18.4%

Uninsured Eligible for expansion to 150% 182 — 8.5%

Uninsured Eligible for Medicaid/SCHIP 314 — 14.7%

Had non-group Coverage under Current law 174 — 8.2%

Had employer coverage under current law 1,068 — 50.2

Total = 2,130,000 People

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

II.   ANALYSIS OF THE INDIVIDUAL MANDATE SCENARIO

Figure 8 shows the number of New York residents by primary insurance status under current law in 2006 (first column). The second and third column of numbers shows the combined impact of the administrative simplification, the FHP expansion for single adults to 150 percent of FPL and the FHP buy-in for people between 150 and 300 percent of FPL. The individual mandate assumes that all people in families with tax filers will take coverage either through their employer (if eligible), Medicaid/FHP (if eligible), or through the Buy-In program.

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Figure 8
Coverage Transition by Provision under the Individual Mandate Scenario

	Current Law	Administrative Simplification + Expansion to 150% + FHP Buy-in		Individual Mandate Coverage Scenario	
		Number of People	Net Change	Number of People	Net Change
ESI	9,717	8,247	-1,470	8,481	+234
Non-Group	469	645	+176	295	-350
Medicaid & FHP	3,546	4,491	+945	4,966	+475
Buy-In Program and Purchasing Pool/Exchange					
Sliding Scale Buy-In (150%-300%FPL)	0	1,185	+1,185	1,493	+308
Buy-in (300%+ FPL - 8/10 % cap)	0	0	0	911	+911
Uninsured [a]	2,805	1,969	-836	390	-1,579
CHAMPUS	144	144	0	144	0
Medicare	2,405	2,405	0	2,405	0

a/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 9 shows the transitions in coverage under the individual mandate proposal after all provisions are in place.

Figure 9
Coverage Transitions under the Individual Mandate Proposal (in 1,000s)

Base Case Coverage	Total	Primary Sources of Coverage Under Proposal							
		Buy-in 150-300% FPL	Buy-in Over 300% FPL	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	9,717	693	391	8,245	0	0	0	380	8
Non-Group	469	102	0	0	295	0	0	72	0
CHAMPUS	144	0	0	0	0	144	0	0	0
Medicare (incl. Dual Eligible)	2,405	0	0	0	0	0	2,405	0	0
Medicaid (w/o Dual Eligible)	3,546	0	0	0	0	0	0	3,546	0
Uninsured	2,805	698	520	236	0	0	0	968	382
Total	**19,087**	**1,493**	**911**	**8,481**	**295**	**144**	**2,405**	**4,966**	**390**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 10 shows the number of people who enroll in Medicaid/FHP or the Buy-In program assuming that both the subsidized premium buy-in and individual mandate are in effect. We estimate there will be about 651,000 people who enroll in Medicaid/FHP due to the mandate and about 1.5 million people who enroll in the buy-in and are eligible for the sliding scale premium subsidies. There will also be about 911,000 uninsured people who purchase coverage because of the mandate. These families will not be eligible for the sliding scale premium subsidies but their premiums will be capped not to exceed 10 percent of family income (8 percent for families below 400% FPL).

Figure 10
Number of People and Costs in Medicaid/FHP and the Buy-in Program [a/]
(Individual Mandate Scenario)

Poverty Level	Number People (1,000s)	Benefit and Admin Costs (millions)	Subsidy Costs (millions)	Net Family Premium Contribution (millions)
Parents and Children below 150% FPL [b/]	380	$733	$733	--
Childless Adults below 150% FPL [b/]	271	$889	$889	--
All between 150-300% FPL	1,493	$5,018	$3,605	$1,413
All 300% FPL and over	911	$3,310	$441	$2,869
Total	**3,055**	**$9,950**	**$5,668**	**$4,282**

a/   Buy-in program assumes the Family Health Plus benefits package and provider payment rates.
b/   Includes 176,000 people who enroll in Medicaid/FHP due to employer dropping coverage in response to the Buy-In and 475,000 people enroll in Medicaid/FHP due to the Individual mandate.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 11 presents the net program costs (i.e., benefits and administrative costs less family premium contributions under the public plans). The table separates the costs for groups that will be eligible for federal matching funds. Overall these programs would cost the state about $5.1 billion in 2006 after accounting for offsets from other programs.

Figure 11
Program Expenditures under Public Plans under the
Individual Mandate Scenario (in millions)

	Net Program [a]	Federal	State [d]
Public Program Costs			
Administrative Simplification	$970	$529	$440
Expansion to 150% FPL for Childless Adults	$718	--	$718
Medicaid/FHP enrollment due to Individual Mandate			
Parents and Children	$733	$400	$333
Childless Adults	$889	$240	$649
Buy-in Program + Individual Mandate Impacts			
Sliding Scale Premium Buy-in to 300% FPL	$3,605	--	$3,605
Public Program Buy-in over 300% FPL	$441	--	$441
Subsidy Administration [b]	$265	--	$265
Healthy New York (HNY) [c]	($65)	--	($65)
Primary Payer Payment	($217)	--	($217)
Safety Net Programs	($1,047)	--	($1,047)
Total Program Costs	**$6,292**	**$1,169**	**$5,123**

a/ Includes benefits and administrative costs for Medicaid and SCHIP and the premium subsidy costs for the buy-in program. Premium subsidies are 100% of premium for persons below 150% FPL, 80% of premium for persons 151-200% FPL, 65% of premium for persons 201-250% FPL, 50% for persons 251-275% FPL, and 25% for persons 276-300% FPL. In addition, there is a limit on premiums to 10 percent of income (8% for families below 400% FPL).
b/ Assumes eligibility determination expense of $171 per application, which is based on the average cost of eligibility determination in public programs in New York.
c/ Savings to the state of reduced spending for HNY when the mandate is introduce. Estimates assume no change in HNY program eligibility.
d/ Does not include changes in tax revenues due to wage effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

III. ANALYSIS OF THE VOLUNTARY PAY OR PLAY COVERAGE SCENARIO

Figure 12 shows the number of New York residents by primary insurance status under current law in 2006 (first column). The second and third column of numbers shows the combined impact of the administrative simplification and the FHP expansion for single adults to 150 percent of FPL. The last two columns show the combined impact of the FHP buy-in for people between 150 and 300 percent of FPL and the voluntary pay or play program. We combined these impacts because the pay or play provisions will impact the employers decision as to whether to continue to offer coverage or pay the tax and allow their employees to purchase coverage on their own through the buy-in. The net change includes coverage changes as firms that do not offer coverage under current law decide to offer coverage under the proposal rather than pay the tax and firms that offered coverage under current law decide to drop their

coverage and pay the tax. In this analysis, we assume that firms with fewer then 10 workers are exempt from the pay or play program.

Figure 13 shows the transitions in coverage under the voluntary pay or play proposal after all provisions are in place.

Figure 12
Coverage Transition by Provision under the Voluntary Pay or Play Proposal (in 1,000s)

	Current Law	Administrative Simplification + Expansion to 150%		FHP Buy-In + Pay or Play (Non-insuring firms offering Coverage)		FHP Buy-In + Pay or Play Voluntary Coverage Scenario	
		Number of People	Net Change	Number of People	Net Change	Number of People	Net Change
ESI	9,717	9,517	-200	9,662	+145	9,070	-592
Non-Group	469	397	-72	373	-24	282	-91
Medicaid & FHP	3,546	4,314	+768	4,314	0	4,337	+23
Buy-In Program and Purchase Pool Exchange							
Sliding Scale Buy-In (150%-300%FPL)	0	0	0	0	0	988	+988
Buy-in (300%+ FPL - 8/10 % cap)	0	0	0	0	0	25	+25
Uninsured [a]	2,805	2,309	-496	2,188	-121	1,835	-353
CHAMPUS	144	144	0	144	0	144	0
Medicare	2,405	2,405	0	2,405	0	2,405	0

a/   Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 13
Coverage Transitions under the Voluntary Pay or Play Proposal (in 1,000s)

Base Case Coverage	Total	Primary Source of Coverage Under Proposal							
		Buy-in 150-300% FPL	Buy-in Over 300% FPL	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	9,717	530	25	8,925	0	0	0	223	14
Non-Group	469	91	0	24	282	0	0	72	0
CHAMPUS	144	0	0	0	0	144	0	0	0
Medicare (incl. Dual Eligible)	2,405	0	0	0	0	0	2,405	0	0
Medicaid (w/o Dual Eligible)	3,546	0	0	0	0	0	0	3,546	0
Uninsured	2,805	367	0	121	0	0	0	496	1,821
Total	**19,087**	**988**	**25**	**9,070**	**282**	**144**	**2,405**	**4,337**	**1,835**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 14 shows the number of people who voluntarily enroll in the buy-in program assuming that both the subsidized premium buy-in and pay or play are both implemented. We estimate there would be about 24,000 people below 150 percent of FPL who previously had employer coverage who will enroll in Medicaid/FHP. We estimate there will be about 988,000 people eligible for the sliding scale premium subsidies. Also, there will be about 25,000 who enroll in the buy-in program after their employer dropped coverage. These families will not be eligible for the sliding scale premium subsidies but premiums will be capped not to exceed 10 percent of family income (8 percent for families below 400 percent of FPL).

Figure 14
Number of People and Costs in Medicaid/SCHIP and the Buy-in Program Due To Pay or Play ^{a/} (Voluntary Coverage Scenario)

Poverty Level	Number People (1,000s)	Benefit and Admin Costs (millions)	Subsidy Costs (millions)	Net Family Premium Contribution (millions)
Parents and Children below 150% FPL	14	$32	$32	--
Childless Adults below 150% FPL	10	$33	$33	--
All between 150-300% FPL	988	$3,677	$2,854	$823
All 300% FPL and over	25	$133	$48	$85
Total	**1,035**	**$3,875**	**$2,967**	**$908**

a/   Buy-in program assumes the Family Health Plus benefits package and provider payment rates.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 15 presents the net program costs (i.e., benefits and administrative costs less family premium contributions under the public plans). The table separates the costs for groups that will be eligible for federal matching funds. We estimate that employers will pay about $1.0 billion in pay or play taxes under the proposal. Firms with fewer than 10 workers are exempt from this requirement. We assumed that federal, state and local governments will continue to offer coverage instead of paying the tax. In addition, we estimate the state would save about $593 million from other safety net programs as about half the previously uninsured become covered. Overall the program would cost the state about $2.4 billion as net public program costs are greater than tax revenues.

Figure 15
Program Expenditures under Public Plans under the
Voluntary Pay or Play Proposal (in millions)

	Net Program [a]	Federal	State [e]
Public Program Costs			
Administrative Simplification	$970	$529	$440
Expansion to 150% FPL for Childless Adults	$718	--	$718
Medicaid/FHP enrollment due to Mandate			
Parents and Children	$32	$18	$14
Childless Adults	$33	$11	$22
Buy-in Program + Pay or Play Impacts			
Sliding Scale Premium Buy-in to 300% FPL	$2,854	--	$2,854
Public Program Buy-in over 300% FPL	$48	--	$48
Subsidy Administration [b]	$91	--	$91
Total Program Costs	**$4,746**	**$558**	**$4,188**
Public Program Offsets			
Payroll Tax Revenues [c]	$1,007	--	$1,007
Healthy New York (HNY) [d]	$38	--	$38
Safety Net Programs	$594	--	$594
Primary Payer Payments	$153	--	$153
Total Program Offsets	**$1,792**	**--**	**$1,801**
Net Program Costs			
Net Costs	**$2,954**	**$558**	**$2,396**

a/ Includes benefits and administrative costs for Medicaid and SCHIP and the premium subsidy costs
for the buy-in program. Premium subsidies are 100% of premium for persons below 150% FPL, 80%
of premium for persons 151-200% FPL, 65% of premium for persons 201-250% FPL, 50% for
persons 251-275% FPL, and 25% for persons 276-300% FPL. In addition, there is a limit on
premiums to 10 percent of income (8% for families below 400% FPL).
b/ Assumes eligibility determination expense of $171 per application, which is based on the average
cost of eligibility determination in public programs in New York.
c/ Employers who do not offer coverage are required to pay an 8 percent payroll tax on wages up to
$250,000 per worker.
d/ Savings to the state of reduced spending for HNY when the mandate is introduce. Estimates assume
no change in HNY eligibility.
e/ Does not include changes in tax revenues due to wage effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

IV. ANALYSIS OF THE MANDATORY PAY OR PLAY COVERAGE SCENARIO

Figure 16 shows the number of New York residents by primary insurance status under current
law in 2006 (first column). The second and third column of numbers shows the combined
impact of the administrative simplification and the FHP expansion for single adults to 150
percent of FPL. The fourth and fifth columns show the combined impact of the FHP buy-in for
people between 150 and 300 percent of FPL and the voluntary pay or play program. We

combined these impacts because the pay or play provisions will impact the employers decision as to whether to continue to offer coverage or pay the tax and allow their employees to purchase coverage on their own through the buy-in. The net change includes coverage changes as firms that do not offer coverage under current law decide to offer coverage under the proposal rather than pay the tax and firms that offered coverage under current law decide to drop their coverage and pay the tax. The remaining columns show the impact of the pay or play proposal with a mandate. In this analysis, we assume that firms with fewer than 10 workers are exempt from the pay or play program. The mandate assumes that all people in families with tax filers will take coverage either through their employer (if eligible), Medicaid/FHP (if eligible), or through the buy-in.

Figure 16
Coverage Transition by Provision under the Mandatory Pay or Play Proposal (in 1,000s)

	Current Law	Administrative Simplification + Expansion to 150%		FHP Buy-in + Pay or Play Voluntary Coverage Scenario		Pay or Play + Mandate	
		Number of People	Net Change	Number of People	Net Change	Number of People	Net Change
ESI	9,717	9,517	-200	9,070	-447	9,337	+267
Non-Group [b]	469	397	-72	282	-115	255	-27
Medicaid & FHP	3,546	4,314	+768	4,337	+23	4,812	+475
Buy-In Program and Purchasing Pool/Exchange							
Sliding Scale Buy-In (150%-300%FPL)	0	0	0	988	+988	1,258	+270
Buy-in (300%+ FPL - 8/10 % cap)	0	0	0	25	+25	517	+492
Uninsured [a]	2,805	2,309	-496	1,835	-474	360	-1,475
CHAMPUS	144	144	0	144	0	144	0
Medicare	2,405	2,405	0	2,405	0	2,405	0

a/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage.
b/ Includes enrollment in FHP buy-in for people above 300 percent of the FPL.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 17 shows the transitions in coverage under the mandatory coverage proposal after all provisions are in place.

Figure 18 shows the number of people who enroll in Medicaid/FHP or the buy-in program assuming that the subsidized premium buy-in, pay or play and the mandate are all implemented. We estimate there would be about 23,000 people below 150 percent of FPL who previously had employer coverage and another 475,000 people who were previously uninsured that will enroll in Medicaid/FHP. We estimate there will be about 1.3 million people eligible for the sliding scale premium subsidies. Also, there will be about 30,000 who purchase coverage after their employer dropped coverage and another 487,000 uninsured. These families will not be eligible for the sliding scale premium subsidies but premiums will be capped not to exceed 10 percent of family income (8 percent for families below 400 percent of FPL).

Figure 17
Coverage Transitions under the Mandatory Pay or Play Proposal (in 1,000s)

Base Case Coverage	Total	Buy-in 150-300% FPL	Buy-in over 300% FPL	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	9,717	530	30	8,922	0	0	0	226	9
Non-Group	469	91	0	53	255	0	0	72	0
CHAMPUS	144	0	0	0	0	144	0	0	0
Medicare (incl. Dual Eligible)	2,405	0	0	0	0	0	2,405	0	0
Medicaid (w/o Dual Eligible)	3,546	0	0	0	0	0	0	3,546	0
Uninsured	2,805	637	487	362	0	0	0	968	351
Total	**19,087**	**1,258**	**517**	**9,337**	**255**	**144**	**2,405**	**4,812**	**360**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 18
Enrollment and Costs In Medicaid/SCHIP and the Buy-in Program under Pay or Play (Mandatory Coverage Scenario) [a]

Poverty Level	Number People (1,000s)	Benefit and Admin Costs (millions)	Subsidy Costs (millions)	Net Family Premium Contribution (millions)
Parents and Children below 150% FPL [b]	289	$533	$533	--
Childless Adults below 150% FPL [b]	209	$696	$696	--
All between 150-300% FPL	1,258	$4,073	$3,020	$1,053
All 300% FPL and over	517	$1,178	$27	$1,151
Total	**2,273**	**$6,480**	**$4,276**	**$2,204**

a/ Buy-in program assumes the Family Health Plus benefits package and provider payment rates.
b/ Includes 23,000 people who enroll in Medicaid/FHP due to employer dropping coverage in response to the Pay or Play and 475,000 people who enroll in Medicaid/FHP due to the Individual mandate.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 19 presents the net program costs (i.e., benefits and administrative costs less family premium contributions under the public plans). The table separates the costs for groups that will be eligible for federal matching funds. We estimate that employers will pay about $1.0 billion in pay or play taxes under the proposal. Firms with fewer than 10 workers are exempt from this requirement. We assumed that federal, state and local governments will continue to offer coverage instead of paying the tax.

In addition, we estimate the state would save about $1.0 billion from other safety net programs as nearly all the previously uninsured become covered. Overall the program as designed would cost the state about $2.9 billion in 2006.

Figure 19
Program Expenditures under Public Plans under the
Mandatory Pay or Play Proposal (in millions)

	Net Program [a]	Federal	State [e]
Public Program Costs			
Administrative Simplification	$970	$529	$440
Expansion to 150% FPL for Childless Adults	$718	--	$718
Medicaid/FHP enrollment due to Pay or Play			
Parents and Children	$533	$291	$242
Childless Adults	$696	$209	$487
Buy-in Program + Pay or Play Impacts			
Sliding Scale Premium Buy-in to 300% FPL	$3,020	--	$3,020
Public Program Buy-in over 300% FPL	$27	--	$27
Subsidy Administration [b]	$207	--	$207
Total Program Costs	**$6,171**	**$891**	**$5,142**
Public Program Offsets			
Payroll Tax Revenues [c]	$1,007	--	$1,007
Healthy New York (HNY) [d]	$36	--	$36
Medicare Primary Payer	$160	--	$160
Safety Net Programs	$1,016	--	$1,016
Total Program Offsets	**$2,219**	**--**	**$2,219**
Net Program Costs			
Net Costs	**$3,952**	**$1,029**	**$2,923**

a/ Includes benefits and administrative costs for Medicaid and SCHIP and the premium subsidy costs for the buy-in program. Premium subsidies are 100% of premium for persons below 150% FPL, 80% of premium for persons 151-200% FPL, 65% of premium for persons 201-250% FPL, 50% for persons 251-275% FPL, and 25% for persons 276-300% FPL. In addition, there is a limit on premiums to 10 percent of income (8% for families below 400% FPL).
b/ Assumes eligibility determination expense of $171 per application, which is based on the average cost of eligibility determination in public programs in New York.
c/ Employers who do not offer coverage are required to pay an 8 percent payroll tax on wages up to $250,000 per worker.
d/ Savings to the state of reduced spending for HNY when the mandate is introduce. Estimates assume no changes in HNY eligibility.
e/ Does not include changes in tax revenues due to wage effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

V. EMPLOYER ASSESSMENT

We estimated the effect of imposing an assessment on employers who do not offer coverage. We assumed that employers are required to make a payment of $400 for each uninsured worker. We assume the assessment does not apply to workers who have coverage from Medicare, CHAMPUS/TriCare, or coverage as a dependent under a spouse or parent's employer sponsored insurance (ESI). Thus, employers are required to pay the assessment on uninsured workers and workers with Medicaid, buy-in or non-group coverage. Similar to the pay or play

options, small firms with under 10 workers are exempt from the assessment. We estimate that there are about 1.2 million workers in the state who meet this definition of an uninsured worker.

The assessment applies to both uninsured workers in firms that do not offer coverage and uninsured workers in insuring firms that are not eligible for the employer's health plan. These typically include part-time and temporary workers. This is important for this analysis because about 25 percent of all uninsured workers are in firms that offer coverage but are not eligible to participate.

We assume that this assessment would be calculated as an amount (i.e., $400) per full-time equivalent (FTE) worker. This effectively reduces the payment for part-time workers and workers who are employed only part of the year. The assessment is assumed to apply to the individual scenario, because under the pay-or-play scenarios, the employer is already paying an assessment (i.e., 8 percent of payroll) if not offering coverage. Using these assumptions, we estimate that the assessment would raise about $418 million.

Figure 20 shows the number of New York residents by primary insurance status under current law in 2006 (first column). The second and third column of numbers shows the combined impact of the administrative simplification, the FHP expansion for single adults to 150 percent of FPL and the FHP buy-in for people between 150 and 300 percent of FPL. The final two columns show the impact of the employer assessment with an individual mandate. The individual mandate assumes that all people in families with tax filers will take coverage either through their employer (if eligible), Medicaid/FHP (if eligible), or through the Buy-In program.

Figure 20
Coverage Transition by Provision under the Employer Assessment with Individual Mandate Scenario

	Current Law	Administrative Simplification + Expansion to 150%		FHP Buy-in + Employer Assessment + Individual Mandate Coverage Scenario	
		Number of People	Net Change	Number of People	Net Change
ESI	9,717	9,517	-200	8,665	-852
Non-Group	469	397	-72	296	-101
Medicaid & FHP	3,546	4,314	+768	4,951	+637
Buy-In Program and Purchasing Pool/Exchange					
Sliding Scale Buy-In (150%-300%FPL)	0	0	0	1,447	+1,447
Buy-in (300%+ FPL - 8/10 % cap)	0	0	0	791	+791
Uninsured [a]	2,805	2,309	-496	388	-1,921
CHAMPUS	144	144	0	144	0
Medicare	2,405	2,405	0	2,405	0

a/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 21 shows the transitions in coverage under the employer assessment with an individual mandate proposal after all provisions are in place.

Figure 21
Coverage Transitions under the Employer Assessment with Individual Mandate Proposal
(in 1,000s)

Base Case Coverage	Total	Primary Sources of Coverage Under Proposal							
		Buy-in 150-300% FPL	Buy-in Over 300% FPL	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	9,717	652	279	8,412	0	0	0	365	9
Non-Group	469	102	0	0	296	0	0	72	0
CHAMPUS	144	0	0	0	0	144	0	0	0
Medicare (incl. Dual Eligible)	2,405	0	0	0	0	0	2,405	0	0
Medicaid (w/o Dual Eligible)	3,546	0	0	0	0	0	0	3,546	0
Uninsured	2,805	693	512	253	0	0	0	968	379
Total	**19,087**	**1,447**	**791**	**8,665**	**296**	**144**	**2,405**	**4,951**	**388**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 22 shows the number of people who enroll in Medicaid/FHP or the Buy-In program assuming that the subsidized premium buy-in, employer assessment and individual mandates are in effect. We estimate there will be about 636,000 people who enroll in Medicaid/FHP due to the mandate and about 1.4 million people who enroll in the buy-in and are eligible for the sliding scale premium subsidies. There will also be about 791,000 uninsured people who purchase coverage because of the mandate. These families will not be eligible for the sliding scale premium subsidies but their premiums will be capped not to exceed 10 percent of family income (8 percent for families below 400% FPL).

Figure 22
Number of People and Costs in Medicaid/FHP and the Buy-in Program [a]
(Employer Assessment with Individual Mandate Scenario)

Poverty Level	Number People (1,000s)	Benefit and Admin Costs (millions)	Subsidy Costs (millions)	Net Family Premium Contribution (millions)
Parents and Children below 150% FPL [b]	371	$716	$716	--
Childless Adults below 150% FPL [b]	265	$869	$869	--
All between 150-300% FPL	1,447	$4,874	$3,521	$1,353
All 300% FPL and over	791	$2,680	$284	$2,396
Total	**2,874**	**$9,139**	**$5,390**	**$3,749**

a/ Buy-in program assumes the Family Health Plus benefits package and provider payment rates.
b/ Includes 161,000 people who enroll in Medicaid/FHP due to employer dropping coverage in response to the Buy-In and 475,000 people enroll in Medicaid/FHP due to the Individual mandate.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 23 presents the net program costs (i.e., benefits and administrative costs less family premium contributions under the public plans). The table separates the costs for groups that will be eligible for federal matching funds. Overall these programs would cost the state about $4.45 billion in 2006 after accounting for offsets from other programs.

Figure 23
Program Expenditures under Public Plans under the
Employer Assessment with Individual Mandate Scenario (in millions)

	Net Program /a	Federal	State d/
Public Program Costs			
Administrative Simplification	$970	$529	$440
Expansion to 150% FPL for Childless Adults	$718	--	$718
Medicaid/FHP enrollment due to Individual Mandate			
Parents and Children	$716	$391	$325
Childless Adults	$869	$234	$635
Buy-in Program + Individual Mandate Impacts			
Sliding Scale Premium Buy-in to 300% FPL	$3,521	--	$3,521
Public Program Buy-in over 300% FPL	$284	--	$284
Subsidy Administration /b	$250	--	$250
Total Program Costs	**$7,328**	**$1,154**	**$6,174**
Public Program Offsets			
Employer Assessment	$418	--	$418
Healthy New York (HNY) /c	$65	--	$65
Primary Payer Payment	$217	--	$217
Safety Net Programs	$1,019	--	$1,019
Net Program Costs	**$5,609**	**$1,154**	**$4,455**

a/ Includes benefits and administrative costs for Medicaid and SCHIP and the premium subsidy costs for the buy-in program. Premium subsidies are 100% of premium for persons below 150% FPL, 80% of premium for persons 151-200% FPL, 65% of premium for persons 201-250% FPL, 50% for persons 251-275% FPL, and 25% for persons 276-300% FPL. In addition, there is a limit on premiums to 10 percent of income (8% for families below 400% FPL).
b/ Assumes eligibility determination expense of $171 per application, which is based on the average cost of eligibility determination in public programs in New York.
c/ Savings to the state of reduced spending for HNY when the mandate is introduce. Estimates assume no change in HNY program eligibility.
d/ Does not include changes in tax revenues due to wage effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

As shown in *Figure 24* the individual voluntary coverage scenario would reduce the number of uninsured by 836,000 people at a cost to the state of about $4.1 billion. If the employer assessment was also implemented, the reduction in the uninsured population would increase to about 852,000 because the assessment would cause a small number of employers to offer insurance (i.e., the assessment effectively increases the cost of not offering insurance). The

assessment revenues reduce the net cost of the program to the state to about $3.5 billion. The net cost of the individual mandate scenario is reduced from about $5.1 billion to about $4.5 billion with the assessment.

Figure 24
Program Costs With and Without an Assessment on Employers for Uninsured Workers

Policy Scenario	Without Assessment on Employers for Uninsured Workers			With Assessment on Employers for Uninsured Workers			
	Net Reduction in Uninsured	State Cost (millions)	State Cost Per Newly Insured Person	Reduction in Uninsured	Assess-ment Revenue	State Cost (millions)	State Cost Per Newly Insured Person
Individual Voluntary Coverage Scenario	836	$4,128	$4,932	852	$428	$3,544	$4,160
Individual Mandatory Coverage Scenario	2,415	$5,123	$2,121	2,417	$418	$4,455	$1,843
Voluntary Pay-or-Play	970	$2,396	$2,470	NA	NA	NA	NA
Mandatory Pay-or-Play	2,445	$2,923	$1,196	NA	NA	NA	NA
Costs Exclusive of Savings to Other Safety Net Programs and Healthy New York Program							
Individual Voluntary Coverage Scenario	836	$4,811	$5,755	852	$428	$4,202	$4,932
Individual Mandatory Coverage Scenario	2,415	$6,235	$2,582	2,417	$418	$5,539	$2,292
Voluntary Pay-or-Play	970	$3,028	$3,122	NA	NA	NA	NA
Mandatory Pay-or-Play	2,445	$3,975	$1,626	NA	NA	NA	NA

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

VI. EXPANDING ELIGIBILITY FOR THE HEALTHY NEW YORK PROGRAM

The Healthy New York (HNY) program provides subsidized private health insurance to certain low-wage employers and low-income individuals. The subsidy comes primarily in the form of a state-funded reinsurance program that reimburses insurers for 90 percent of costs between $5,000 and $75,000 for each eligible participant. The program is available to small employers who have not offered coverage in the past 12 months are eligible for this coverage if they have 50 or fewer employees and at least thirty percent of the employees earn $32,000 or less annually. Sole proprietors and working individuals are eligible if they are living below 250 percent of the federal poverty level (FPL) and have been uninsured for 12 or more months.

We project that the program will cover about 117,900 people in 2006 at a cost to the state of $67.6 million.

In this analysis, we estimated the impact of several options for expanding enrollment in the program. These changes include:

- Increase income eligibility level for sole proprietors and individuals from 250 percent of the FPL to 300 percent of the FPL, with no change to other eligibility rules;

- Eliminate the 12 months without coverage rule for all eligible groups including individuals, sole proprietors and small groups;

- Eliminate the "low-wage small firm requirement" that 30 percent of workers must earn below $34,000;

- Increase the firm size eligibility requirement from 50 to 100 workers; and

- Expand HNY benefits by aligning the mental health, prescription drug, and cost sharing levels with Family Health Plus.

Adopting these changes in the HNY program would increase enrollment from its current level of about 117,900 people to about 952,200 people. Total subsidy costs would increase from $67.6 million under current law to $811.9 million with the expansions in eligibility.

Health New York enrollment and costs are reduced dramatically if the various expansions in FHP eligibility are adopted. As shown in *Figure 25*, adopting these expansions with the mandate would reduce enrollment to about 4,600. This reflects the fact that for nearly all individuals and sole proprietors eligible for the HNY program, the cost of enrolling in FHP to the individual would be substantially less than the cost of HNY coverage, even after adjusting for the reinsurance subsidy.

Figure 25
Healthy New York Program Enrollment and Subsidy Cost Under
Alternative Coverage Expansion Proposals

Policy Scenario	Current Law Healthy New York		Healthy New York with Eligibility Expansions	
	Total Enrolled	Total Subsidy Cost (millions)	Total Enrolled	Total Subsidy Cost (millions)
Current Policy	117,925	$67.6	952,175	$811.9
Individual Coverage Expansions				
FHP Expansions: Voluntary	3,394	$1.9	26,378	$118.5
FHP Expansions: Mandatory	4,640	$2.6	34,260	$153.8
Pay or Play				
Pay or Play: Voluntary	50,379	$30.1	579,633	$494.1
Pay or Play: Mandatory	51,683	$31.4	590,607	$503.3

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Enrollment would increase to about 51,700 people if pay-or-play were implemented together with the mandate and the FHP expansions. This reflects the fact that many of the Health NY eligible employers who adopt coverage due to pay-or-play would find that the Health NY premium is less than the cost of private insurance.

VII. COVERING MEDICAID AND SCHIP ELIGIBLE BUT NOT ENROLLED PEOPLE

In *Appendix A*, we provide a detailed analysis of the likely effects of various administrative simplification proposals on enrollment of people who are already eligible for but not enrolled in Medicaid and SCHIP. We estimate that there are about 1.2 million uninsured people in New York who are uninsured even though they are eligible for these programs. We estimated that the combined effect of the administrative simplifications that we examined would increase Medicaid and SCHIP enrollment by about 480,000 people, of whom 313,800 people would have been uninsured (see *Figure 3* above). This is about 27.0 percent of the 1.2 million uninsured people who are eligible but not enrolled.

These estimates reveal two important conclusions. First, we have concluded that efforts to increase enrollment among those who are eligible will still leave a substantial portion of the eligible population without insurance. Second, some of the people who would be enrolled are already covered by some other source of coverage.

As an illustrative exercise, we have estimated the cost of covering all of the uninsured people who are eligible but not enrolled in the Medicaid and SCHIP programs in New York. We estimate that there are on average of 7.0 million people in New York who are eligible for these programs in any given month, of which about 4.5 million are enrolled (64.3 percent). Of the 2.5 million Medicaid eligible people who do not enroll, about 1.2 million are uninsured. *Figure 26* presents the distribution of eligible but not enrolled people by age.

Figure 26
Average Monthly Medicaid Eligible Population in New York by
Enrollment and Uninsured Status
(thousands)

Age	Eligible for Medicaid	Enrolled in Medicaid	Eligible Not Enrolled	
			Total	Uninsured
Less than 19	2,654.0	1,972.2	681.8	287.5
19 -24	1,108.2	553.1	555.1	228.9
25 – 34	718.8	495.7	223.1	213.6
35 – 44	808.1	458.3	349.8	189.2
45 – 54	566.1	359.2	206.9	135.2
55 – 64	515.4	327.0	188.4	100.0
65 and older	655.4	386.2	269.4	3.8
Total	**7,026.1**	**4,551.7**	**2,476.4**	**1,158.2**

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Using the health plan capitation rates now used in the Medicaid program, we estimate that covering this population would cost about $2.6 billion in 2006 (*Figure 27*). This is about $184.04 per-member per-month (PMPM). The state share would be $1.2 billion.

Figure 27
Cost of Covering All Uninsured People in New York who are Eligible for Medicaid or SCHIP but are not Enrolled

Age	Medicaid Eligible But Not Enrolled (thousands)	Cost of Coverage (millions)	Federal Share (millions)	State Share (millions)	PMPM Costs
Children	287.5	$342.1	$180.8	$161.3	$99.15
Adults	870.7	$2,215.7	$1,152.2	$1,063.5	$212.06
Total	**1,158.2**	**$2,557.8**	**$1,333.0**	**$1,224.8**	**$184.04**

Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These estimates probably exceed the actual cost of covering this group. The existing health plan capitation rates reflect the cost profiles of those who are enrolled in the existing program. These people are likely to be more costly than those who do not enroll simply because people with health needs are more likely to seek coverage. For example, many of those on the program are enrolled through hospitals when they present in the emergency room with health needs.

Our own analyses of the Medical Expenditures Panel Survey (MEPS) data indicates that the uninsured are up to 25 percent less costly than their insured counterparts, even after adjusting for insurance status. Thus, the health plan capitation rates for this population are likely higher than the cost of covering this population. This probably would be reflected in future negotiations of capitation rates with the plans.

Appendix A

Expanding Coverage through Administrative Simplification and Subsidized Coverage

In this report, we present our estimates of the impact of several steps that could be taken to increase enrollment in the New York Medicaid and SCHIP programs. These include proposals that would simplify the process of enrollment, such as self-certification of income, the "express lane" enrollment model, elimination of the assets test, and biennial review of eligibility. We also include estimates of expanding eligibility under the Family Health Plus (FHP) program including:

- Increase the income eligibility level for single adults under FHP to 150 percent of the federal poverty level (FPL); and

- Create a subsidized buy-in to FHP for families and single adults with incomes between 150 percent and 300 percent of the FPL.

We also present estimates of the cost and coverage impacts of implementing all of these proposals together. Additional analyses of several variations on the buy-in model and changes in the HNY program are currently underway.

We found that adopting all of these proposals in a combined approach would reduce the number of uninsured in New York by about 836,700 people, of which 222,700 would be children. Enrollment in Medicaid and SCHIP would increase by about 2.1 million people. Total program costs, including premium subsidies under the buy-in, would be about $5.7 billion in 2006. Of this, $772.7 million would be paid with federal matching funds, with the state paying about $4.9 billion. We present our estimates and the data and methods used in the following sections:

- Eligibility simplification;
- Program cost assumptions;
- Self certification of income;
- Express lane eligibility;
- Elimination of the assets test;
- Biennial review of eligibility;
- Increasing eligibility under FHP for single adults;
- Subsidized FHP buy-in program; and
- Summary of estimates.

A. Eligibility Simplification

The Center on Budget Policy Priorities has compiled a list of steps that states can take to simplify the process of applying for and renewing coverage under Medicaid an SCHIP. *Figure A-1* shows which of these steps have been adopted in New York.[1]

Figure A-1
Summary of Eligibility Simplification Steps Adopted for New York

	Child Health Plus A	Child Health Plus B	Medicaid for Parents	Family Health Plans: Parents	Family Health Plus: Childless Adults
Initial Application					
Joint Application	Y	Y	Y	Y	Y
No Face-to-face Interview		Y			
No Asset Test	Y	Y			
Presumptive Eligibility		Y			
Self-certification of Income					
Self-certification of Residence					
Self-certification of Age					
Self-certification of Assets	NA	NA	Y	Y	Y
Renewal					
Renewal Frequency (months)	12	12	12	12	12
12-month Certification	Y	Y			
No Face-to-face Interview	Y	Y	Y	Y	Y
Joint Renewal	Y	Y	Y	Y	Y
Self-certification of Assets	NA	NA	Y	Y	Y
Self-certification of Income		Y			

Source: Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," (report to the Kaiser Family Foundation Commission on Medicaid and the Uninsured), Center on Budget and Policy Priorities, October 2004.

Like most states, New York has a joint application form for Medicaid and SCHIP for children and family coverage. The assets test has been eliminated for children under Child Health Plus A (CHP-A) and CHP-B, but is retained for parents and single adults under Medicaid and FHP. For these groups, the program permits self-certification of assets which reduces the amount of documentation applicants must provide at application and renewal of eligibility. The face-to-face interview requirement at initial application has been eliminated for CHP-B only, and is eliminated for all enrollees at time of renewal. Presumptive eligibility has been adopted only for the CHP-B program. New York still requires applicants to provide documentation of income, age, and residence at application. However, self-certification of income is permitted in the CHP-B program at renewal only.

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[1] Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," (report to the Kaiser Family Foundation Commission on Medicaid and the Uninsured), Center on Budget and Policy Priorities, October 2004.

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The state requires renewal of eligibility every 12 months for each category of eligibility. Under both CHP-A and CHP-B, children are certified for a full 12 months, which means that their eligibility continues for a full year even if there is a change in eligibility. For all other eligibility groups, eligibility can be terminated between renewal periods if there is a change in circumstances affecting eligibility, such as an increase in income.

B. Program Cost Assumptions

Throughout this analysis, we estimate the cost of covering newly eligible people based upon costs under the existing program for similar eligibility groups. For people enrolling in FHP, we used the statewide average capitation rates for FHP health plans for the 2004/2005 period. These include separate rates for parents, childless adults age 19 to 29 and childless adults age 30 to 64. For CHP-B, we used the statewide average capitation payment under that program (i.e., SCHIP).

For people enrolling in the CHP-A or the Medicaid program for parents, we used the statewide average capitation payments for the Temporary Assistance for Needy Families (TANF) enrollees and Safety-net enrollees (TANF/SN). Separate rates are provided for TANF enrollees age 21 to 64, TANF/SN females age 6 months to 14 years; TANF/SN females age 15 to 20; and males age 6months to age 20 (for children we used a weighted average of the rates for children).

For CHP-A and Medicaid enrollees, we increased the rates by six percent to reflect the cost of services that are provided outside of the capitation amount.

We also included program administrative costs in all of these estimates, which we assume to be equal to three percent of capitation payments to health plans under all four programs (i.e., CHP-A, CHP-B, FHP and Medicaid). We inflated the capitation rates to calendar year 2006 levels assuming a six percent increase in rates. *Figure A-2* presents the costs assumed per-person per-month (PMPM) by eligibility group throughout our analysis.

Figure A-2
Per Person Per Month (PMPM) Costs Assumed for Newly Eligible Enrollees
by Eligibility Group in 2006 [a/]

	Children	Parents	Single Adults	
			19 – 29	30 – 64
FHP	--	$272	$249	$365
CHP-A [b/]	$109 [c/]	--	--	--
CHP-B	$147	--	--	--
Medicaid [b/]	--	$217 [d/]	$200 [e/]	$308

a/ All estimates based upon health plan capitation rates in FHP, CHIP-B, CHIP-A and Medicaid. Estimates adjusted to 2006 assuming update of 6 percent. Assumes 3 percent program administration.
b/ Include an additional 6 percent for services not included in the health plan capitation rates.
c/ Composite rate based upon weighted average of rates for TANF and Safety-net eligible children for: females age 6 months to age 14; females age 15 to 20; and males age 6 months to age 20.
d/ Uses rates for TANF eligible people age 21 to 64.
e/ Uses rates for safety-net eligible adults age 21 to 29 (same for males and females.
Source: Lewin Group Estimates based upon statewide average health plan capitation rates by program and class of eligibility.

We assume that costs would be lower than shown in *Figure A-2* for currently eligible but not enrolled people. This estimate is based upon results from the Health Benefits Simulation Model (HBSM) indicating that currently eligible but not enrolled people upon becoming covered would use about 25 percent fewer health services than currently enrolled people with similar characteristics.[2] This result is consistent with the hypothesis that those who are eligible but not enrolled in the program include relatively low users of care who have not been inclined to seek medical assistance.

C. Self-Certification of Income

Under current practices, applicants are required to provide documentation of income such as pay stubs or tax information. This documentation is required for all groups at initial application, and is required for all groups except CHP-B at renewal. As required in federal law, the state verifies reported income with the automated income and eligibility verification system (IEVS) and other sources following eligibility determination. However, federal law permits states to allow individuals to self-certify income, thus eliminating the requirement that applicants provide documentation for these items as they apply for the programs. Reported amounts would continue to be verified after eligibility determinations are made to assure accuracy and minimize errors in eligibility determinations. [3]

Self-certification of income is currently allowed in 13 states when applying for children's Medicaid or SCHIP.[4] In 7 of these 13 states, parents can self-certify income when applying for coverage themselves. Many of these states have experienced increases in enrollment, although it is difficult to isolate the impact of this change from the effects of other changes occurring at the same time in the program and the eligible population.[5] Most state officials report increased case worker productivity and increased speed of eligibility determination. Many states have also eliminated or simplified the assets test.

Some of the available evidence on the impact of self-certification of income includes:

- **Michigan:** Implemented self-certification of income in Medicaid and SCHIP. Enrollment increased by 8.5 percent;

- **Ohio:** Implemented self-declaration of income for children in one county. Enrollment is reported to have increased by 24,000 children;

- **Washington:** Reinstated documentation of income, eliminated 12 months of continuous eligibility and reduced the recertification period to 6 months. Medicaid enrollment declined by 11 percent;

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[2] "Documentation of the Health Benefits Simulation Model," (report to the Robert Wood Johnson Foundation (RWJF)), The Lewin Group, October 2004.

[3] "Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Centers for Medicare and Medicaid Services (CMS), August 2001.

[4] Ross, D.C., Cox, L. (June 2002). *Enrolling Children and Families in Health Coverage: The Promise of Doing More.* Kaiser Commission on Medicaid and the Uninsured. Arkansas, Connecticut, Florida, Georgia, Idaho, Maryland, Michigan, Mississippi, Oklahoma, Vermont, Washington, Wisconsin, and Wyoming allow self-certification of income when applying for children's coverage in Medicaid.

[5] Danielle Holahan and Elise Hubert, "Lessons from States with Self-Declaration of Income Policies," The United Hospital Fund, 2004.

- **Wisconsin:** Reinstated documentation of income and required written verification of insurance status from employer. Enrollment declined by 11.3 percent; and

- **Wyoming:** Allowed self-declaration of income for families and eliminated the face-to-face interview. A large increase in enrollment is reported.

The impact of self-certification of enrollment is difficult to discern from these results because they were implemented together with other changes in the eligibility process. Also, most states saw a significant increase in enrollment during the same period regardless of whether steps were taken to simplify the eligibility process. Thus, it is difficult to isolate the effect of self-certification on enrollment.

A recent study by Kronenbusch and Elbel attempted to isolate the effect of self-certification of income on enrollment from other factors contributing to enrollment trends.[6] They developed a multivariate model of enrollment of children in Medicaid and SCHIP nationally, controlling for the various enrollment procedures in each state. The data on Medicaid enrollment are based upon the Current Population Survey (CPS), which provides information on Medicaid enrollment for a representative sample of families across the country.

This study indicates that self-certification of income increases enrollment of children in Medicaid and SCHIP by about 3.5 percent, after controlling for other effects. In our analysis, we assume that adopting self-certification of income in New York would increase enrollment by 3.5 percent for both children and adults in Medicaid/SCHIP (i.e., excluding the aged and disabled). These estimates were adjusted to reflect a general under-reporting of Medicaid enrollment in the CPS, which can affect the magnitude of estimated effects.[7]

Using these data, we estimate that average monthly enrollment in Medicaid and SCHIP in New York would increase by about 71,400 people (*Figure A-3*). This includes 40,300 children and 31,100 adults. Benefits and administrative costs for these people would be about $112.3 million. This estimate reflects our assumption that costs for currently eligible but not enrolled people would be about 25 percent lower than for similarly situated people who are already participating in the program (as discussed above).

Adopting self-certification of income would also reduce the costs of processing eligibility throughout the program. We estimated these savings based upon a Lewin Group study of adopting self-certification of income under the Medi-Cal program in California, which showed that eliminating the income documentation requirement would reduce the cost of processing eligibility by about 2.5 percent.[8] Based upon this assumption, we estimate a savings in administrative costs of about $5.4 million. Total costs net of administrative savings due to self-certification of income would be about $106.9 million in 2006, of which the state share would be $51.1 million (*Figure A-3*).

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[6]   K. Kronenbusch and B. Elbel, "Enrolling Children in Public Insurance: SCHIP, Medicaid and State Implementation," *Journal of Health Politics, Policy, and Law*, Vol. 29, No. 3, June 2004.

[7]   The CPS underreports the number of people on Medicaid and SCHIP by about one-third. To adjust for this, we estimated the increase in enrollment using the CPS reported data on enrollment in the New York Medicaid program.

[8]   Lisa Chimento, "Simplifying the Medi-Cal Program: Opportunities and Challenges in Tight Fiscal Times," (report to the Medi-Cal Policy Institute), The Lewin Group, 2003.

Figure A-3
Estimated Impact of Enrollment Simplification Proposals on Program Cost and Coverage [a/]

	Newly Enrolled				Costs for New Enrollees ($1,000 s)	Admin- istrative Savings ($1,000 s)	Total Net Costs ($1,000 s)	Federal Share ($1,000 s)	State Share ($1,000 s)	PMPM Cost
	Total	Now with ESI	Now with Non-group	Reduction in Uninsured						
Self certification of income										
Children	40,339	3,632	1,411	35,296	$43,137	($2,286)	$40,851	$21,430	$19,421	$89.11
Adults	31,023	2,559	1,318	27,145	$69,169	($3,159)	$66,011	$34,326	$31,685	$185.80
Total	71,362	6,191	2,729	62,441	$112,306	($5,445)	$106,862	$55,756	$51,106	$131.15
Express Lane Eligibility										
Children	40,004	3,581	1,393	35,030	$42,778	--	$42,778	$22,501	$20,277	$89.11
Adults	12,490	1,030	531	10,929	$27,850	--	$27,850	$14,482	$13,368	$185.81
Total	52,494	4,611	1,924	45,959	$70,628	--	$70,628	$36,983	$33,645	$112.12
Eliminate Assets Test										
Children	2,069	976	593	500	$2,976	--	$2,976	$1,577	$1,399	$119.86
Adults	91,777	43,875	25,734	22,168	$266,074	($11,431)	$254,643	$132,414	$122,229	$241.60
Total	93,846	44,851	26,327	22,668	$269,050	($11,431)	$257,619	$133,991	$123,628	$238.91
Modified Biennial Review										
Children	207,771	74,451	12,120	121,200	$223,419	($25,500)	$197,919	$104,896	$93,023	$89.61
Adults	87,929	3,510	719	83,700	$190,353	($12,750)	$177,603	$92,354	$85,249	$180.40
Total	295,700	77,961	12,839	204,900	$413,772	($38,250)	$375,522	$188,642	$178,272	$116.61
Combined Effect										
Children	262,500	73,467	13,833	175,200	$312,310	($27,786)	$284,524	$150,404	$134,120	$99.15
Adults	217,500	45,316	33,584	138,600	$553,446	($27,340)	$526,107	$273,576	$252,531	$212.05
Total	480,000	118,783	47,417	313,800	$865,756	($55,126)	$810,631	$423,980	$386,651	$150.30

a/ Figures do not add to total due to overlapping effects.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

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Figure A-3 also shows the distribution of newly enrolled people by coverage status under current policy including people with non-group coverage and employer sponsored insurance (ESI).

D. Implement an "Express Lane" Enrollment Process

"Express Lane" enrollment is a process whereby people who have qualified for benefits under other income-tested programs are automatically directed to the Medicaid/SCHIP programs if they appear to be eligible. With the permission of the applicant, income and other information also would be forwarded to Medicaid/SCHIP so that applicants are not required to repeat the process of documenting their incomes. Income-tested programs are those where eligibility for the program is determined on the basis of applicant income. Some of the largest of these income-tested programs are Food Stamps, the Women Infants and Children (WIC) program, and the National Free School Lunch program.

For example, the Food Stamp program determines eligibility (and the benefit amount) on the basis of the incomes reported for people living in each applicant household. If the applicant agrees, the income and other data collected in the process of determining Food Stamp eligibility could be forwarded to the Medicaid and SCHIP programs for people who appear to be eligible. Ideally, Medicaid/SCHIP eligibility could be determined on the basis of this information resulting in automatic enrollment. Alternatively, people could be enrolled on a basis of presumptive eligibility, contingent upon further clarification of eligibility through the application process.

To illustrate, *Figure A-4* presents the percentage of uninsured children and adults who are receiving food stamps by income level in New York.[9] These data show that 44.1 percent of all uninsured children and 22.7 percent of all uninsured adults living below the FPL are receiving food stamps. In fact, using these data, we estimate that if all Medicaid/SCHIP eligible people were to be identified and automatically enrolled, the number of uninsured in the state would be reduced by about 169,400 people. This includes about 120,400 children and 49,000 adults.

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[9] Estimates are based upon a Lewin Group Analysis of the New York sub-sample of the Survey of Income and Program Participation (SIPP) for 2001 and 2002.

Figure A-4
Percent of Uninsured People in New York Enrolled in the Food Stamp
Program by Family Income as a Percent of the Federal Poverty Level (FPL)

Income as % of FPL	Children	Adults
<100%	44.1%	22.7%
100-150%	33.6%	16.3%
150-200%	17.2 %	7.6%
200-250%	0.0%	8.4%
250-300%	4.0%	4.7%
300-400%	1.7%	6.8%
400+%	1.2%	2.7%
Total	22.5%	10.8%

Source: Lewin Group Analysis of the New York sub-sample of the Survey of Income and Program Participation (SIPP) data.

There are barriers to implementing such an approach. For example, the information required to determine eligibility for Food Stamps and Medicaid/SCHIP would need to be standardized. We would also need to adapt the system to accommodate differences in eligibility for these programs in federal law. For example, Food Stamp eligibility is based upon the income and resources of all people living together in a single household regardless of relation, while Medicaid eligibility is determined for individual sub-parts of the household such as families, children, pregnant women, and childless adults. Thus, in some cases, not all of those who are included in a household for purposes of Food Stamp eligibility will be eligible for Medicaid or SCHIP.

Resolving these issues would take time. For example, Medi-Cal of California is currently pilot testing in four counties an automated eligibility system called "One-E-App," which consolidates applications for health programs. A unified application process that includes Food Stamps has not yet been developed for the state, although there are plans to expand the system to include applications for non-health programs such as Food Stamps. Thus, New York would need to invest resources in systems development to automate the process.[10]

An alternative approach would be to facilitate the application process by notifying Food Stamp recipients who appear to be eligible of their potential eligibility for Medicaid/SCHIP. In addition, Food Stamp eligibility case-workers would ask applicants for permission to forward their income and other data to the Medicaid/SCHIP office so that applicants do not need to repeat the process of providing required information and documentation. Children and perhaps

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[10] Lisa Chimento, Anna Theisen-Olson and Maya Bhat, "Electronic Applications Present Opportunities to Improve Enrollment in New York's Public Health Insurance Programs", (report to the United Hospital Fund), The Lewin Group, November 2004.

adults could then be granted presumptive eligibility under these programs until a determination can be made.[11]

We base our estimates of take-up under this version of "express lane" enrollment on an evaluation of an ongoing pilot program in four California counties. In that pilot project, parents of children who are determined to be eligible for the free school lunch program are notified of their potential eligibility for Medicaid/SCHIP and are asked for permission to forward the income information to the appropriate agency to initiate the application process. This program has been disappointing because only about 10 percent of parents provide consent, which is believed to be attributed to the fact that the children themselves are asked to deliver information materials to their parents. However, for those who provide consent, only about 31 percent ultimately enrolled. The remaining 69 percent were denied enrollment, primarily due to failure to provide necessary documentation.[12]

In this analysis, we assume that express lane eligibility would take the form of notifying Food Stamp applicants of their apparent eligibility for Medicaid or SCHIP and would ask permission from these individuals to forward this information to the appropriate agency. Unlike the program in California, this transaction would occur directly between the case worker and the adult applicant. We assume that 31 percent would ultimately complete the application process and qualify for the program, as in the California program.

Using these assumptions, we estimate that this provision would add about 52,500 people to the Medicaid and SCHIP programs, of whom about 40,000 would be children (*Figure 3* above). This would reduce the number of uninsured in New York by about 46,000 people. Program costs would be about $70.6 million, of which the state share would be $33.6 million.

Enrollment could also be further enhanced by providing similar notification for other programs such as WIC, although this would include a smaller number of people, most of whom are likely already covered under Medicaid. However, we do not include the free school program in the express lane program due to the disappointing results under the California pilot programs.

E. Eliminate Assets Test For Non-aged Non-disabled Adults

Another step towards simplification of enrollment would be eliminating the assets test. Under the current program, there is no assets test for the CHP-A and CHP-B programs covering children. Families and childless adults face a limit on assets as a condition of eligibility for Medicaid and FHP (there is also an assets test for the aged and disabled). However, income-eligible children in families that do not meet the asset limits can qualify under CHP-A.

Figure A-5 summarizes the resource limits now used in the program and the types of assets included. The assets limit, which varies with family size, is $4,000 for a single applicant and

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[11] Dawn C. Horner et al., "Building an On-Ramp to Children's Health Coverage: A Report on California's Express Lane Eligibility Program," (report to the Kaiser Family Foundation (KFF)), the Children's Partnership, September 2004.

[12] Michael Cousineau, Dr.PH et al., "Express Lane Eligibility Evaluation Project: Data Analysis from 4 Pilot Projects," Progress Report, Division of Community Health, University of Southern California, October 2004.

about $5,950 for a family of four. Assets include financial assets and the fair market value of an automobile over $4,650. The value of the home is not counted towards the assets test.

**Figure A-5**
Summary of Assets Test in New York for 2005 [a/]

Number in Family	Medicaid Resource Limits	FHP Resource Limits
1	$4,000	$12,000
2	$5,850	$17,150
3	$5,900	$17,300
4	$5,950	$17,450
5	$6,000	$17,600
6	$6,800	$20,000
7	$7,650	$22,550
8	$8,500	$25,100
for each additional person, add	$850	$2,550

Resources Included

Bank accounts
Stocks
Bonds
Life insurance cash Surrender value
401K, IRA
Real property Other than home
Automobiles over $4,650

a/ Income and Resource Levels are subject to yearly adjustments.
Source: New York Medicaid program.

In this analysis, we estimated the impact of eliminating the assets test for non-aged non-disabled adults using the New York sub-sample of the SIPP data for 2001 and 2002. These data provide detailed income and assets information for a representative sample of the population in the state. Using these data, we estimated the number of people meeting the income eligibility levels under the program who have assets in excess of the resource limits under the program.

We estimate that eliminating the assets test for non-aged non-disabled adults would result in another 209,300 adults eligible for the program (i.e., average monthly newly eligible adults). These are adults who already meet the income eligibility criteria but have assets greater than the assets limits. Despite their lower incomes, only about 14.7 percent of these people are uninsured. About 71.1 percent have employer coverage and about 12.6 percent have private non-group coverage (*Figure A-6*). These data suggest that this population is composed largely of people with some level of resources experiencing temporary reductions in income.

Figure A-6
Number of Newly Eligible People Due to Elimination of the Assets Test for
Non-aged Non-disabled Adults by Current Coverage Status

Other Sources
3,262
1.6%

Non-Group
Coverage
26,327

12.6%

Uninsured
30,787

14.7%

71.1%

Employer
Coverage
148,903
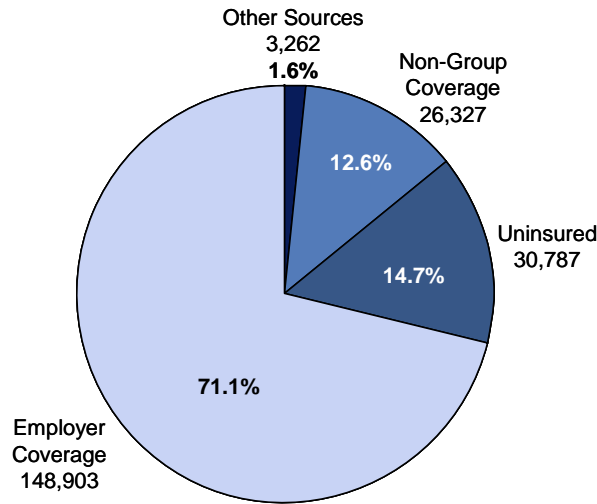
Number Newly Eligible = 209,279

Source: Lewin Group estimates using the SIPP data for 2001 and 2002.

We estimated the number of newly eligible people who would enroll in the program using participation rates that we estimated from historical data using our models and program data. These data indicate that about 72 percent of currently uninsured people would enroll while only about 39 percent of those with coverage from other sources would enroll. Using these assumptions, we estimate an increase in enrollment of about 91,800 adults, which is an increase in adult enrollment of about 6.3 percent. This result is consistent with the Kronenbusch and Elbel study (discussed above) which showed that enrollment in states that have eliminated the assets test increased by about 6.1 percent.

We also estimate that about 2,100 children would also become enrolled, bringing the total increase in enrollment to 93,800. These are children who are eligible but not enrolled in the Medicaid program who would become enrolled as a newly eligible parent(s) is enrolled in the program. Of the 93,800 people who would be newly enrolled, about 22,700 would otherwise have been uninsured.

Using the cost assumptions described above, we estimate that eliminating the assets test would increase program costs by about $269.1 million. We estimate that this increase in cost would be partly offset with administrative savings of about $11.4 million by eliminating the cost of administering the assets test for all non-aged non-disabled adults. This estimate is based upon an earlier Lewin Group study in California showing that eliminating the assets test would reduce administrative costs by about 12.5 percent.

The total net cost of dropping the assets test would be about $257.6 million, of which the state share would be about $123.6 million.

G. Biennial Review of Eligibility

Under a biennial review model, Medicaid participants are required to go through a detailed review of their eligibility once every two years, with post card renewal in intervening years. This compares with the current practice of conducting detailed reviews of eligibility every 12 months. The purpose of this approach is to simplify the steps that eligible Medicaid and SCHIP participants must take to remain covered under the program.

The SIPP data for New York, indicates that there are about 77,300 children and non-aged non-disabled adults who dis-enroll from the New York Medicaid and SCHIP programs each month (*Figure A-7*). Of those who dis-enroll, about 61 percent become uninsured even though they appear to be eligible to renew their eligibility at the time of their dis-enrollment. In addition, these data indicate that about 67 percent of those who dis-enroll will re-enroll in the program within 12 months.

Figure A-7
Summary of Medicaid/SCHIP Disenrollment in New York by
Program Eligibility at Termination

	Average Monthly Disenrollment							Percent of Dis-enrollees Re-Enrolled Within 12 Months
	Total	Appear Eligible But Become Uninsured		Appear Eligible but Take Private Coverage		Appear Ineligible		
		Number	Percent	Number	Percent	Number	Percent	
Children	43,842	33,587	76.6%	7,237	16.5%	3,018	6.9%	84.4%
Adults	33,479	13,592	40.6%	1,132	3.4%	18,755	56.0%	44.6%
Total	77,321	47,179	61.0%	8,369	10.8%	21,773	28.2%	67.1%

Source: The Lewin Group analysis of the Survey of Income and Program Participation (SIPP) for 2001 and 2002.

Much of this "churning" of coverage occurs among children. About 76.6 percent of children who dis-enrolled from the program became uninsured even though they appear to be eligible to renew their coverage at the time of their dis-enrollment. About 84.4 percent of children dis-enrolling from the program are re-enrolled within 12 months.

These results suggest that many Medicaid eligible people move on and off of the Medicaid and SCHIP roles throughout the year, even though they continue to be eligible. This leaves gaps in coverage that could be avoided by retaining eligible people in the program once they are enrolled.

Under the current program, people who are found to be eligible for CHP-A, CHP-B, FHP, and Medicaid (i.e., non-aged non-disabled) are certified for a period of 12 months (see *Figure A-1* above). At the end of that 12 month period, enrollees are required to go through a detailed renewal of their eligibility, including documentation of income. If they continue to be eligible for the program, they are certified for another 12-month period. Eligible children under CHP-A

and CHP-B are also provided with 12 months of continuous eligibility once determined to be eligible (at both initial application and renewal). This means that once children are determined/re-determined to be eligible, they continue to be enrolled for a period of 12 continuous months regardless of changes in eligibility occurring during the year.

In this analysis, we estimated the effect of a biennial review process that requires full recertification only once every other year. During intervening years, participants would be required to return a post card indicating whether their income or circumstances have changed. People who report no changes on the post card would be recertified for another 12 months of continuous eligibility. Thus, the primary difference between biennial review and current practices is that the detailed recertification process now conducted annually would be replaced in every other year with a post card renewal approach, thus making it easier for eligible people to renew their eligibility.

It is not clear how much this change would differ from the current process. The face-to-face interview at renewal (and initial application) has already been eliminated in New York, and self-certification of assets is permitted for adults (there is no assets test for children). The key difference in biennial review is that only a post card is required after the first 12 months rather than the current detailed renewal performed through the mail and over the telephone. The post card approach implies that the documentation now required at renewal is eliminated, which would greatly facilitate continued enrollment. However, the impact of eliminating documentation requirements is largely overlapping with the effects of eliminating the assets test and adopting self-certification of income, as discussed above.

We simulated the effect of this provision assuming that the use of the post card approach would reduce by half the number of eligible people who are dis-enrolled from the program for failure to fill out the forms and provide necessary documentation. Using the New York SIPP data for 2001 and 2002, we identified people who dis-enrolled from the program even though they appear to be eligible at termination. We then estimated the effect on enrollment assuming that half of these people become recertified for another year due to the simplified post card approach.

Under this assumption, we estimate that average monthly enrollment under Medicaid and SCHIP would increase by about 295,700 people, which is an 8.4 percent increase in program enrollment (see *Figure A-3* above). The number of uninsured would be reduced by about 204,900 people, including 121,200 children and 83,700 adults. The net cost of adopting this approach would be $375.5 million, of which the state share would be $178.3 million.[13]

H. Increase FHP Eligibility for Childless Adults to 150 Percent of the FPL

In this analysis, we estimated the impact of increasing income eligibility for childless adults under FHP from its current level of 100 percent of the FPL to 150 percent of the FPL. We developed these estimates using the Lewin Group Health Benefits Simulation Model (HBSM). The model is based upon the New York sub-sample of the Current Population Survey (CPS)

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[13] We assume that the cost of administering enrollment, estimated to be $171 per application, would be reduced by about one-eighth by adopting biennial enrollment.

data for March of 2003 and 2004, which provides information on health insurance coverage, income, and other demographic characteristics for the state. The model also uses the Medicaid Expenditures Panel Survey (MEPS) for 1999 through 2001 to provide health services utilization and expenditures information not available in the CPS.[14] The methods used to adapt the model for use in New York are presented in *Appendix B*.

HBSM uses actual program income eligibility levels to distinguish currently eligible but not enrolled people from those who would become newly eligible under the expansion. The model uses a month-by-month simulation methodology designed to identify people eligible for only part of the year. The model then estimates the number of newly eligible people who would enroll based upon multivariate analyses of program enrollment patterns in the existing Medicaid program. These analyses show how enrollment in the program varies by age, income, employment status, coverage under employer plans (i.e., crowd-out), premium contribution requirements, and several other demographic variables.

Some of the key participation assumptions used include:

- Our multivariate model of Medicaid participation typically predicts an average participation rate of about 70 percent for uninsured people and about 39 percent for people who currently have insurance from some other source. Participation declines at higher income levels.

- We assumed that children currently eligible for Medicaid or SCHIP (SCHIP covers children through 200 percent of the FPL) who are not enrolled would become covered under the program if one of their parents becomes covered under the expansion. We assume no change in coverage for other eligible people who are not enrolled.

- All newly eligible adults who currently have private non-group coverage are assumed to discontinue that coverage to enroll in the program.

We also assumed that the increase in eligibility would result in coverage for some of those childless adults who are currently eligible but not enrolled. In several instances, it has been observed that when eligibility levels are increased, there tends to be a corresponding increase in enrollment among those who are already eligible but not enrolled. This is thought to be due to increased program awareness in general due to the publicity and outreach associated with the eligibility expansion. For example, a Mathematica Policy Research inc. study of an expansion in eligibility for children in Santa Clara County California indicated that each newly eligible child who enrolled was associated with an increase in enrollment of 0.86 children who are already eligible under current law.[15] We estimate that this is about 17 percent of all eligible but not enrolled children in the area.

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[14] A key step in reconciling the CPS data with program data was to correct for the under-reporting of Medicaid coverage in the CPS.

[15] Christopher Trenholm and Sean Orzol,"The Impact of the Children's Health Initiative (CHI) of Santa Clara County on Medi-Cal and Healthy Families Enrollment," (report to the David and Lucile Packard Foundation), Mathematica Policy Research, inc., September 2004.

In this analysis, we estimated this "spill-over" effect resulting from an increase in eligibility for childless adults. We did this by assuming that the increase in enrollment for the newly eligible would be accompanied by enrollment of about 17 percent of currently eligible but not enrolled childless adults.

Using this approach, we estimate that the expansion in eligibility to 150 percent of the FPL would add about 323,800 childless adults to the program, of whom about 213,100 would be uninsured under current law (*Figure A-8*). Federal funds would not be available for newly eligible childless adults. However, federal matching funds would be available for currently eligible but not enrolled childless adults who become enrolled through the spill-over effect. Total costs would be $1.0 billion, of which the state share would be $730.0 million.

Figure A-8
Estimated Impact of Increasing Family Health Plus Eligibility to
150 Percent of the FPL for Childless Adults [a/]

	Newly Enrolled				Costs for New Enrollees (millions)	Federal Share (millions)	State Share (millions)	PMPM
	Total Enrollment	Now with ESI	Now with Non-group	Reduction in Uninsured				
Increase FHP Eligibility for Childless Adults to 150 percent of the FPL								
Newly Eligible Adults	209,607	73,840	22,583	113,184	$717.6	--	$717.6	$285.31
Currently Eligible Adults "spillover effect"	114,240	9,425	4,855	99,960	$302.7	$157.4	$145.3	$220.80
Total Impact								
Total	323,847	83,265	27,430	213,144	$1,020.3	$157.4	$862.9	$262.55

a/   Assumes no waiting period for program enrollment.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

I. A Subsidized Buy-in to FHP

Under this scenario, families and childless adults living between 150 percent and 300 percent of the FPL would be permitted to buy-in to the FHP program. The program would have a premium based upon costs under the FHP program that would vary on a sliding scale with income. Benefits and co-payments would be same as under FHP. Employers would be allowed to buy-in to coverage so long as they contribute at least 50 percent of the premium. We developed these estimate with and without a waiting period requirement as a means of limiting crowd-out. Under the scenario with an anti crowd-out provisions, we assume employers and individuals are required to have been without ESI for at least 6 months before enrollment, except for those experiencing an involuntary termination of coverage (job loss etc).

The premium subsidies under this program have the effect of lowering the cost of insurance for affected people, which would induce many eligible individuals to take coverage. We simulated the increase in coverage using an HBSM multivariate model of how the likelihood of purchasing coverage changes as the price of coverage (i.e., the premium) is reduced. This model

shows an average price elasticity for coverage of –0.34 (i.e., a 1.0 percent decrease in premiums is associated with an increase in coverage of about 0.34 percent).[16] However, the model shows that the effect of changes in premiums on coverage varies with the income and demographic characteristics of the people affected. For example, the price elasticity varies from about –0.31 among people with family income of $50,000 to –0.55 among those with incomes of $10,000. Thus, the price response tends to be higher for low-income people than higher-income people. Similar patterns exist by age and other factors included in the model.

In the first step we identify potentially eligible people within HBSM. We then compared the subsidized FHP premium with what they would have to pay for comparable coverage in the non-group market. We then used the price elasticity model to estimate the effect that this premium reduction would have on the likelihood of taking coverage for eligible people. We used these likelihood estimates as a basis to estimate the number of eligible people who would enroll.

We simulated the buy-in under alternative premium subsidy schedules. Option A would provide premium subsidies at all levels of income through 300 percent of the FPL. Option B would provide lower subsidy amounts and would not provide subsidies to people living between 275 and 300 percent of the FPL. We assume that the buy-in would be implemented together with the expansion in eligibility to 150 percent of the FPL for childless adults under FHP.

Percent of Premium Subsidized by Income as a percent of the FPL

Income as Percent of FPL	Option A	Option B
Less than <150% of FPL	100%	100%
151-200% of FPL	80%	75%
201-250% of FPL	65%	50%
251-275% of FPL	50%	25%
276-300% of FPL	25%	0%

We also simulated the program with and without a six-month waiting period requirement. Under this provision, income eligible people must have been without coverage for at least six months prior to enrollment. This is designed to discourage workers and employers from discontinuing employer-sponsored insurance (ESI) and shit to the publicly subsidized public program (i.e., crowd-out). This approach is known as an "anti crowd-out" provision.

We estimate that there would be about 1.0 million people who would be eligible for subsidized coverage under the FHP buy-in, assuming the plan has a six-month waiting period. Under the more generous of the two subsidy schedules (i.e., Option A), about 669,200 people would enroll (*Figure A-9-A*). This includes about 465,200 people who are currently uninsured and about 104,500 income eligible people who are currently purchasing non-group coverage, whom we expect to shift to the subsidized buy-in. The total cost of subsidies provided under the program would be about $2.2 billion. Under the less generous subsidy schedule, the number of uninsured is reduced by about 374,900 people, with program subsidy costs of about $1.7 billion (*Figure A-9-B*).

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[16] John Sheils and Randall Haught,, "Documentation of the Health Benefits Simulation Model (HBSM)," (report to the Robert Wood Johnson Foundation (RWJF)), The Lewin Group, October 2004.

Figure A-9-A
Impact of a Subsidized FHP Buy-in for People Between 150 Percent and 300 Percent of the FPL under Subsidy Option A (Highest Subsidy Percent) [a/]

	Newly Enrolled (1,000s)	Now with ESI (1,000s)	Now with Non-group (1,000s)	Uninsured (1,000s)	Program Costs (millions)	Subsidies (millions)[b/]
FHP Buy-In *With* Anti-Crowd-Out Provisions (i.e., 6-month waiting period)						
Children	123.9	9.3	15.2	99.4	$212.9	$164.1
Parents	208.0	19.4	19.2	169.4	$659.9	$509.1
Childless Adults	337.3	70.8	70.1	196.4	$1,278.9	$974.6
Total	669.2	99.5	104.5	465.2	$2,151.7	$1,647.8
FHP Buy-In *Without* Anti-Crowd-Out Provisions (i.e., no waiting period)						
Children	184.8	70.2	15.2	99.4	$317.5	$244.8
Parents	459.4	270.8	19.2	169.4	$1,457.4	$1,124.8
Childless Adults	980.6	714.1	70.1	196.4	$3,717.4	$2,862.4
Total	1,624.8	1,055.1	104.5	465.2	$5,492.3	$4,232.0

a/ Does not include the impacts of adopting the simplification provisions and increasing FHP eligibility to 150 percent of the FPL for childless adults. Consequently, these results will differ from scenarios where these three elements are implemented together (i.e., combined scenarios).

b/ Subsidy percent option A: 151-200% FPL, 80%; 201-250% FPL, 65%; 251-300% FPL, 50%; 275 and 300% of the FPL, 25%.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure A-9-B
Impact of a Subsidized FHP Buy-in for People Between 150 Percent and 300 Percent of the FPL Under Subsidy Option B (Lower Subsidy Percent) [a/]

	Newly Enrolled (1,000s)	Now with ESI (1,000s)	Now with Non-group (1,000s)	Uninsured (1,000s)	Program Costs (millions)	Subsidies (millions)[b/]
FHP Buy-In *With* Anti-Crowd-Out Provisions (i.e., 6-month waiting period)						
Children	100.5	6.8	11.1	82.6	$172.6	$129.4
Parents	170.1	15.7	15.5	138.9	$538.7	$405.0
Childless Adults	271.4	59.3	58.7	153.4	$1,028.3	$746.4
Total	542.0	81.8	85.3	374.7	$1,739.6	$1,280.0
FHP Buy-In *Without* Anti-Group Out Provision (i.e., no waiting period)						
Children	146.6	52.9	11.1	82.6	$251.9	$161.0
Parents	374.4	220.0	15.5	138.9	$1,185.7	$810.9
Childless Adults	802.7	590.6	58.7	153.4	$3,041.3	$2,207.6
Total	1,323.7	863.5	85.3	374.9	$4,478.9	$3,179.5

a/ Does not include the cost of adopting the simplification provisions and increasing income eligibility under FHP to 150 percent of the FPL for childless adults. Consequently, these results will differ from scenarios where these three elements are implemented together (i.e., combined scenarios) as presented in the text of this report.

b/ Subsidy percent option B: 151-200% FPL, 75%; 201-250% FPL, 50%; 251-275% FPL, 25%; and 276-300% FPL, 0%.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figures A-9-B and *A-9-B* also show enrollment and costs under options A and B without the anti-crowd-out provisions. This scenario results in a substantial number of people with ESI shifting to the buy-in. This substantially increases total enrollment and costs under the program under both scenarios.

J. Summary of Cost and Coverage Effects

Implementing the administrative simplification proposals together would result in an increase in program enrollment of about 480,000 people (*FigureA-10*). This includes elimination of the assets test, self-certification of income, express lane enrollment, and biennial eligibility review. The number of uninsured would be reduced by about 313,800 people, including 175,200 children and 138,600 adults. The total cost of adopting these simplifications would be $810.6 million, of which $424.0 million would be paid by the federal government and $386.6 million would be paid by the state. These estimates reflect overlapping impacts of implementing these changes.

Figure A-10 also shows the impact of implementing the administrative simplifications together with an increase in eligibility for childless adults to 150 percent of the FPL. Under this combined approach, enrollment would increase by a total of 768,400 people. The number of people without health insurance would be reduced by about 496,000. The program would cost about $1.7 billion assuming full implementation in 2006. Federal matching funds would be available for newly enrolling people who are already eligible and those who become eligible with the elimination of the assets test, amounting to $529.3 million in 2006. The state share of costs would be about $1.2 billion.

Figure A-10
Summary of the Cost and Coverage Impacts of Combining Various Approaches for Expanding Insurance Coverage in New York [a/]

	Newly Enrolled (1,000s)	Reduction in Uninsured (1,000s)	Costs for New Enrollees [b/] (millions)	Federal Share (millions)	State Share (millions)
Combined Effects of Administrative Simplifications					
Children	262.5	175.2	$284.5	$150.4	$134.1
Adults	217.5	138.6	$526.1	$273.6	$252.5
Total	480.0	313.8	$810.6	$424.0	$386.6
Administrative Simplifications Combined with FHP Expansion to 150% of FPL for Childless Adults					
Children	262.5	175.2	$284.5	$150.4	$134.1
Adults	505.9	320.8	$1,403.2	$378.9	$1,024.3
Total	768.4	496.0	$1,687.7	$529.3	$1,158.4
Administrative Simplifications With FHP Expansion and Buy-in Through 300% of the FPL [c/]					
Children	453.4	222.7	$559.5	$222.6	$336.9
Adults	1,676.2	614.0	$5,097.2	$550.1	$4,547.1
Total	2,129.6	836.7	$5,656.7	$772.7	$4,884.0

a/ Figures may not sum to total due to overlapping effects of proposals. Estimates Include new benefits and administrative cost savings.
b/ Net impact on uninsured includes the number of uninsured under current law who enroll in the Buy-In net of the increase in uninsured people due to employers dropping coverage (52,000 people).
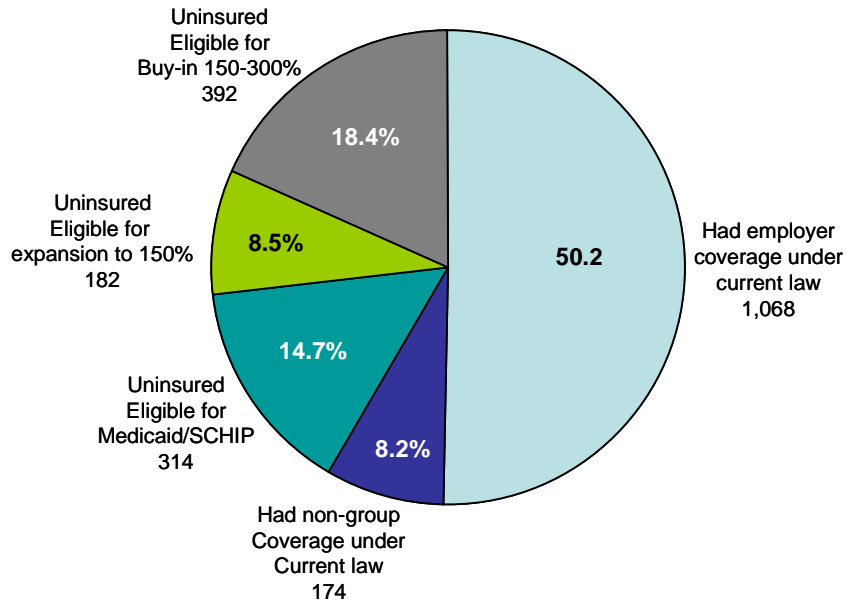c/ Assumes FHP buy-in premium subsidy percent option A, without the six-month waiting period requirement.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Finally, we estimated the impact of implementing the FHP buy-in for people living between 150 percent and 300 percent of the FPL (premium subsidy option A), together with the administrative simplification, and eligibility expansion to 150 percent of the FPL for childless adults. We assume no waiting period requirement under the FHP buy-in. Under this scenario, enrollment in Medicaid and SCHIP would increase by about 2.1 million people. The number of uninsured would decline by about 836,000 people of whom, 222,700 would be children. Total program costs, including premium subsidies under the buy-in, would be about $5.7 billion in 2006. Federal funds would be $772.7 million with the state paying about $4.9 billion.

About 2.1 million people would receive subsidized coverage under the combined program (*Figure A-11*). These include people enrolled through administrative simplification, the FHP expansion to 150 percent of the FPL for childless adults, and the FHP buy-in for people living between 150 percent and 300 percent of the FPL. Of the 2.1 million people receiving subsidized coverage, 836,000 (41 percent) are people who would have been uninsured in the absence of the program. The remainder would be people who shift to subsidized coverage from private employer or non-group coverage.

Figure A-11
People Obtaining Subsidized Coverage Under the Combined Policy (in 1,000s)

Uninsured Eligible for Buy-in 150-300% 392 — 18.4%

Uninsured Eligible for expansion to 150% 182 — 8.5%

Uninsured Eligible for Medicaid/SCHIP 314 — 14.7%

Had non-group Coverage under Current law 174 — 8.2%

Had employer coverage under current law 1,068 — 50.2

Total = 2,130,000 People

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure A-12 presents the distribution of uninsured people in New York in 2006 under current law and the number of uninsured who would become covered by family income, age and income as a percent of the FPL. We also present the distribution of people eligible for Medicaid or SCHIP and the number of those people who become insured under the program by income and age. We estimate that about 836,700 of the 2.8 million (34 percent) uninsured people in the state of New York would become insured under the combined policy. Also, of the 1.2 million uninsured who are eligible for but not enrolled in Medicaid and SCHIP, about 382,800 (33.1 percent) would become covered.

Figure A-12
Change in Number of Uninsured in New York Under the Combined Policy

	All Uninsured In State		Uninsured Already Eligible for Medicaid or SCHIP	
	Total	Newly Covered	Total	Newly Covered
Family Income [a]				
Less than $10,000	514.1	160.6	415.9	166.7
$10,000-$19,999	586.9	254.2	261.6	88.1
$20,000-$29,999	486.8	180.4	184.2	52.7
$30,000-$39,999	357.7	124.0	121.1	38.4
$40,000-$49,999	202.3	64.4	58.9	19.1
$50,000-$74,999	295.1	44.6	59.4	12.0
$75,000-$99,999	149.7	7.5	26.0	4.9
$100,000-$149,999	130.4	0.3	18.8	0.4
$150,000 & over	81.8	0.7	12.2	0.7
Age				
<19	555.2	229.1	287.5	175.2
19-24	493.8	137.9	228.9	56.4
25-34	562.5	143.7	213.6	51.0
35-44	515.6	142.6	189.2	40.3
45-54	390.4	101.2	135.2	34.0
55-64	279.3	80.3	100.0	24.9
65 +	7.8	1.9	3.9	1.1
Total	**2,804.7**	**836.7**	**1,158.2**	**382.8**

a/ The uninsured are distributed by "program filing unit" income, where adult family members without children and/or childless married couples are treated as separate from parents with children. Each of these subsets of a family are called program filing units for purposes of determining eligibility. Thus the distribution by income will differ from the distribution by census family units, where all related members living in a household are counted as one family.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).