



**TESTIMONY OF
THE UNITED HOSPITAL FUND
AND
THE COMMONWEALTH FUND**

**Before the
New York State Insurance Department
and New York State Department of Health
“Partnership for Coverage” Public Hearing**

**December 5, 2007
Old Westbury, New York**

The views presented here are those of the authors and not necessarily those of the United Hospital Fund, The Commonwealth Fund, or their directors, officers, or staff. This and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund’s Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1083.

TESTIMONY OF THE UNITED HOSPITAL FUND AND THE COMMONWEALTH FUND

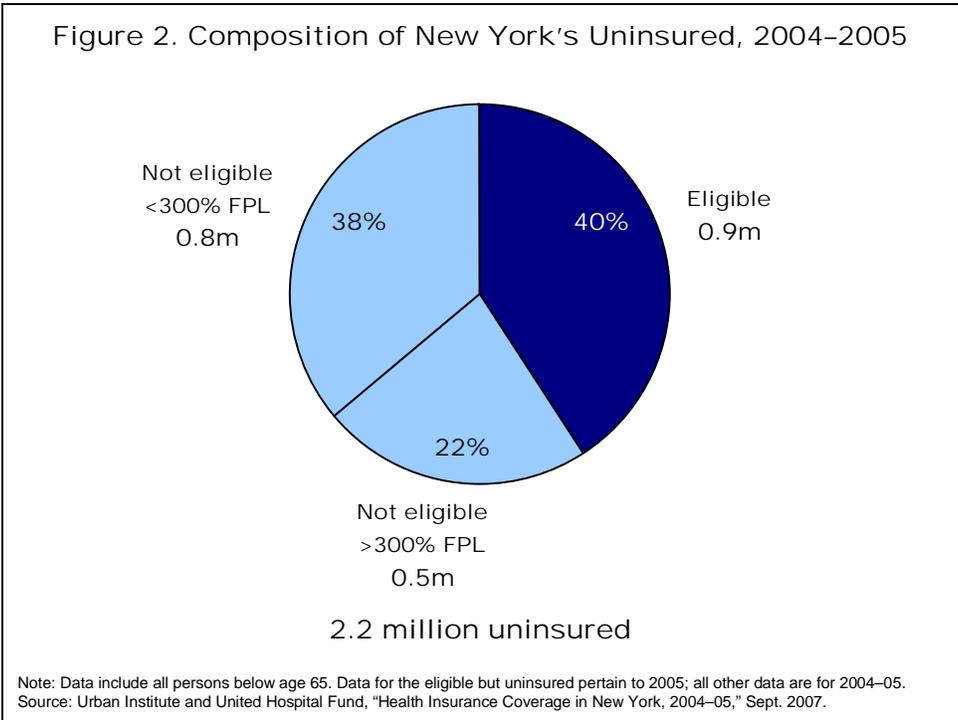
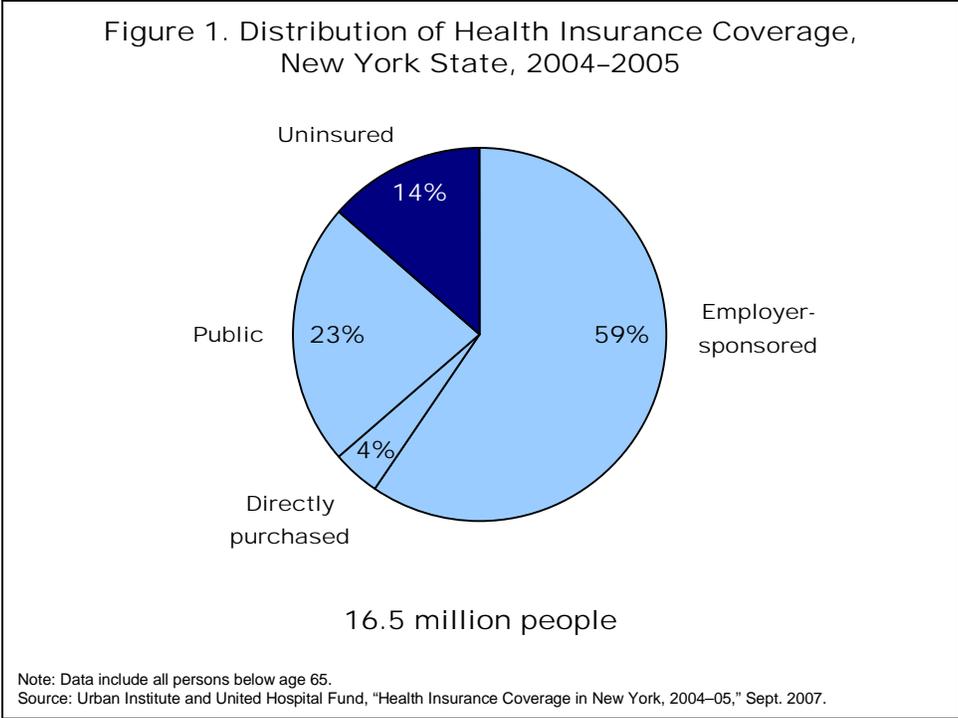
Good morning, we are Danielle Holahan and Peter Newell, senior health policy analysts at United Hospital Fund, and Cathy Schoen, senior vice president at The Commonwealth Fund. We thank you for this opportunity to address the subject of increasing health insurance coverage in New York State. Our organizations have spent many years analyzing issues related to health insurance coverage expansion, including our two-year collaborative to develop *A Blueprint for Universal Health Insurance Coverage in New York*. With this background, and reflections from the previous “Partnership for Coverage” hearings, we offer our comments on key issues to consider with regard to designing approaches to universal coverage in New York State.

BACKGROUND

According to the United Hospital Fund’s most recent analysis, 59 percent of non-elderly residents of New York State have employer-sponsored coverage, 23 percent have public coverage, 4 percent have directly purchased coverage, and the remaining 14 percent are uninsured (Figure 1). However, coverage within these categories is not static—people move in and out of different categories as well as lose and gain insurance. Even for individuals and families who have health insurance, coverage is often unstable, uncertain, or increasingly unaffordable. In the employer-sponsored insurance market, premiums have been rising, forcing many employers to require higher premium contributions and cost-sharing from their workers. As coverage becomes less affordable, employer-sponsored coverage has been gradually eroding.¹ Premiums have also been rising dramatically in the direct-pay market and are largely unaffordable for low-to-moderate income New Yorkers.² In addition, the problem of churning among public program beneficiaries—or cycling on and off coverage despite continued eligibility—is well documented.³ Coverage expansion strategies will need to address the issues of the uninsured, underinsured, and unstably insured New Yorkers.

Expansion strategies will also need to consider the unique composition of New York’s uninsured. We estimate that 40 percent of the state’s 2.2 million uninsured persons are eligible for existing public coverage, another 38 percent have income below 300 percent of the federal poverty level (FPL) but are not eligible for public coverage, and the remaining 22 percent have income above 300 percent FPL (Figure 2).⁴ Research evidence suggests that there are a variety of reasons uninsured children, adolescents, and adults do not enroll in public coverage despite being eligible for these programs,

including: misperception of eligibility rules, difficulty applying and renewing coverage, immigration-related concerns, and misunderstanding among healthier persons about the “value” of coverage.⁵



PRINCIPLES FOR REFORM

We begin by describing a series of principles for reform, outlined by The Commonwealth Fund's Commission on a High Performance Health System, by which universal coverage proposals can be evaluated.⁶ These principles pertain to ways of increasing access to coverage for the uninsured, improving quality and efficiency, and gaining control over health care cost growth.

Access to Care

- Provides equitable and comprehensive insurance for all.
- Insures the population in a way that leads to full and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Coverage is automatic and stable with seamless transitions to maintain enrollment.
- Provides a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Health risks are pooled across broad groups and over lifespans; insurance practices designed to avoid poor health are eliminated.
- Fosters efficiency by reducing complexity for patients and providers, and reducing transaction and administrative costs as a share of premiums.
- Works to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimizes dislocation; people can maintain current coverage if desired.
- Simple to administer.
- Has the potential to lower health care cost growth.

Financing

- Financial commitment to achieve these principles.

- Financing should be adequate and fair, based on ability to pay, and is a shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

With these overarching goals in mind, we offer a series of design choices and key considerations for approaching universal coverage in New York State.

DESIGN CHOICES AND KEY CONSIDERATIONS

At the outset, the state must answer the fundamental question of whether to build its expansion on the current system or to pursue a new system altogether. We believe that reform that builds upon the strengths, and accepts the complexities, of the current system is the most pragmatic approach to achieving universal coverage because it will minimize the dislocation of coverage for those with good coverage. As such, we focus our comments on mixed public-private approaches that build on the best features of the current system and share responsibility for financing across government, employers, and individuals.

Public Program Reform

The Spitzer administration has already committed to an expansion of public coverage through the Child Health Plus (CHP) expansion and the employer buy-in to Family Health Plus (FHP), and to simplification of public program procedures in order to enroll more eligible persons. Further, through the FHP buy-in, the state has also taken a step toward blending the FHP and CHP programs. The state could build upon these initiatives by making more adults eligible for subsidized coverage and by further simplifying and enhancing public program administration to increase participation rates. As described above, we estimate that 40 percent of the uninsured are eligible for a public program. Enrollment of eligible persons is a cost-effective strategy relative to other coverage expansions because of the availability of federal matching funds and because, as research evidence suggests, the “eligible but uninsured” are less expensive than their insured counterparts.⁷

Blueprint modeling indicated that traditional simplification reforms would only enroll a limited share of eligible but uninsured, thus new and non-traditional strategies will be needed.⁸ Four public program simplification reforms were modeled: self-declaration of income, express lane eligibility, biennial renewal, and elimination of the Medicaid and FHP asset test (both a simplification and an eligibility expansion). The modeling results indicated that the combination of these four reforms would enroll only 27 percent of New York’s eligible but uninsured; two-thirds of which was attributed to biennial renewal. Each of these policy changes may be worth pursuing, but non-traditional solutions will also be needed to enroll a larger share of the eligible but

uninsured. Experience in other states and other benefit programs suggest that strategies such as automatic enrollment, administrative renewal, ex-parte review and telephone renewal may also hold promise for New York.

As part of its health care reform efforts, Massachusetts auto-enrolled residents with income below 100 percent FPL who were enrolled in the state's free care pool into Commonwealth Care (the state's new subsidized coverage program). Further, auto-enrollment has been successful in Medicare as well as retirement savings account programs.⁹ In addition, Louisiana has achieved significantly improved renewal rates as a result of its streamlined renewal process incorporating both ex-parte review and telephone renewal.¹⁰ Forthcoming United Hospital Fund reports will describe the characteristics of the eligible but uninsured population in greater detail and provide lessons from other states regarding Medicaid program administration and promising approaches to public program simplification.¹¹

Defining Affordability

Determining the share of income people can afford to spend on health insurance coverage is both an economic and political exercise. In the research literature, there are two primary methods for assessing affordability: the first considers household budgets, measuring the cost of necessities and treating health care as a residual discretionary expense; the second considers what share of income insured persons spend on premiums and out-of-pocket expenses as a benchmark for affordability. Analysis by Jon Gruber (conducted as part of Massachusetts' health care reform effort) comparing expenditures on necessities to family income under the "household budget" approach indicates that:

- families with income below 150 percent of the federal poverty level (FPL) have little or no money for premiums;¹²
- families with income between 150 percent–300 percent FPL can afford modest premiums; and
- families with income above 300 percent FPL have substantial resources beyond necessities and most can afford full premiums.¹³

Under an alternative approach, the Urban Institute analyzed spending by insured persons for private coverage. This analysis focuses on spending among persons with income between 300 percent and 499 percent FPL, indicating that this is a reasonable benchmark for the maximum percent of income people should be expected to pay, because people with income below this level are less likely to have private coverage and

those who do spend a significant portion of income on health care expenses.¹⁴ The analysis finds that persons at this income level spend on average 13.2 percent of income on *total* health care costs (11.5% toward premiums and 1.8% toward out-of-pocket expenses) and suggests that this should be the maximum share of income expected, with contributions scaling down for persons with income below 300 percent FPL.¹⁵ The authors caution that when determining what persons with income below 300 percent FPL can afford, it is important to consider the fixed cost of necessities that will consume a relatively large share of lower-income persons’ income, and suggest that this decision will ultimately reflect a social and political judgment.

Similar affordability analyses focused on New York are being conducted by the Community Service Society and Manatt Health Solutions, with funding from the United Hospital Fund.

As a component of its health care reform initiative, Massachusetts adopted an affordability schedule for the share of income people are required to pay toward premiums. If coverage is not available at these costs, persons are exempt from the mandate.¹⁶

Percent of Federal Poverty Level	Share of Income Required
Below 150% FPL	0%
150%–200% FPL	2.1%–2.7%
200%–250% FPL	3.3%–4.1%
250%–300% FPL	4.1%–4.9%
300%–350% FPL	5.1%–5.9%
350%–400% FPL	6.0%–6.9%
400%–500% FPL	7.2%–9.0%

There is an emerging consensus across states that persons below 300 percent FPL require subsidies toward coverage: Massachusetts, Maine, and Vermont subsidize persons with income below this level in their health care reform initiatives; as would California and Pennsylvania under current proposals.¹⁷

- Massachusetts fully subsidizes all residents with income below 150 percent FPL, provides sliding scale subsidies to residents with income between 150 percent–300 percent FPL, and defined the minimum level of coverage required to satisfy the state’s coverage mandate. “Minimum creditable coverage,” as defined by the

Massachusetts Insurance Connector Board, is considered to be relatively generous with regard to the benefits included, but permits relatively high deductibles. Finally, the state resolved that 20 percent of the uninsured, or 1 percent of state residents, are likely to be exempt from the mandate because affordable coverage is not available to them.¹⁸

- Maine provides sliding scale subsidies to residents with income below 300 percent FPL. Subsidies scale from 80 percent of the total premium for persons with income below 149 percent FPL to 20 percent for persons with income between 250 percent–299 percent FPL. Similarly, deductibles increase as income increases, starting at \$250 for persons with income below 149 percent FPL and increasing to \$1,250 for persons with income above 300 percent FPL.¹⁹
- Vermont provides sliding scale subsidies to uninsured residents with income below 300 percent FPL. Subsidies scale from approximately 80 percent for persons with income below 200 percent FPL to approximately 60 percent for persons with income between 275 percent–300 percent FPL.²⁰
- California’s Governor and legislature are still negotiating the details of health care reform. Under the Governor’s proposal, persons with income below 150 percent FPL would be fully subsidized, those with income below 250 percent FPL would receive sliding scale subsidies to cap premium contributions at 5 percent of income, and those with income between 250 percent–350 percent FPL would receive tax credits to cap contributions at 5 percent of income. The legislature’s “compromise” proposal is similar, but goes further: sliding scale subsidies would end at 300 percent FPL and tax credits would end at 450 percent FPL.
- Under “Cover All Pennsylvanians,” Governor Rendell proposes a new, private insurance market product to be offered to all uninsured residents and low-wage, small firms. The state would subsidize premiums on a sliding scale for individuals with income below 300 percent FPL; eligible employers would also receive government assistance with premiums.

A corollary of affordability is adequacy of coverage. In the context of a coverage expansion, the state will need to balance the desire for “adequate” coverage with the desire to keep coverage affordable. Furthermore, the attractiveness of state-subsidized coverage will also affect employer decisions to stop offering coverage directly. There are three levers available to reduce the cost of insurance coverage: reduce covered benefits,

increase the cost sharing required, and limit provider networks. In the context of a coverage mandate, the state can lower the costs of coverage to individuals, short of direct regulation of rates, by providing generous subsidies or mandating “cheap,” or limited, coverage (again, by limiting the benefits included, cost sharing required, or the networks included). Alternatively, the state can resolve that available coverage is not affordable for all residents and exempt some from the coverage mandate (i.e., those for whom available coverage is not affordable are not required to purchase coverage).

When considering standards for benefit adequacy, it will be important to consider the growing problem of underinsurance. Earlier research by The Commonwealth Fund has defined “underinsured” as being insured all year but with out-of-pocket expenses exceeding 10 percent of income (5% of income for persons with income below 200% FPL).²¹ Further, there has been poignant testimony at earlier “Partnership for Coverage” hearings about the consequences of limited benefits on people’s health and well-being. The Glens Falls hearing featured testimony on this point from a mother describing her son’s harrowing spiral into depression, schizophrenia and homelessness—and his remarkable recovery—only to find himself enrolled in Healthy NY with neither a prescription drug benefit nor a mental health benefit, and drug expenses of \$1,200 a month for the four medications he was taking to successfully control his illness. In Buffalo, you heard from a nine-year breast cancer survivor whose family could not afford the COBRA premiums to maintain comprehensive coverage under her husband’s former employer and switched coverage to a more limited plan through her own employer. The family now faces unreimbursed expenses of \$260 per week for her ongoing cancer treatment.

Economist Jon Gruber refers to the competing pressures of the desire for affordable coverage, comprehensive coverage, and minimized public costs as the “iron triangle.” Defining what individuals should be required to pay toward coverage will necessarily determine what other payers (employers and government) will be responsible for. If sufficient employer and/or government financing is not available, those that cannot afford coverage will remain uninsured. In the end, determining how much individuals should be expected to contribute toward coverage is a political decision.

Remaking New York’s Insurance Markets

It is essential that a universal coverage effort include a clear-eyed look at New York’s insurance market, both from the perspective of how it will support coverage expansion efforts, and a real-time examination of how New Yorkers are served by the market today. With 74 percent of uninsured workers in New York without access to coverage through an employer,²² New York in particular must find other ways to connect these workers

with quality health care coverage through a revamped purchasing pool that spreads risks among the broadest possible group of insureds, and makes comprehensive products available that are affordable at various income levels.

Purchasing Pool Design Presents Challenges and Opportunities

When considering the design of a new purchasing pool to accommodate a coverage expansion, the state faces a complicated and delicate task involving many interlocking decisions. For example, New York must decide whether it will continue to mandate that health plans offer some products (as it does with Healthy New York [HNY] and the direct pay market) and rely on a voluntary participation (as is the case with Medicaid Managed Care [MMC], Family Health Plus [FHP] and Child Health Plus [CHP]). If the decision is for a voluntary scheme, policymakers should consider what blend of “carrots and sticks” would produce the best result.

More fundamentally, New York must also decide whether it will maintain its current system in which public and private markets are operated and regulated separately by different agencies and under different rules. As you know, MMC and FHP are administered by the Department of Health (DOH) which prior approves rates for nonprofit and for profit health plans that voluntarily offer coverage under the programs. The State Insurance Department (SID) plays a limited role in the programs, but establishes rates for a third program, CHP, on a prior approval basis. At the same time, the SID regulates the commercial insurance market for direct pay, small group, HNY and large group, where rates are “file and use” or experience-rated, and the DOH plays a more limited role in vetting provider networks, quality standards, and contracts for HMOs.

Managing these markets will become more complicated in the years ahead as New York make decisions as to how best to extend coverage to its uninsured, the subsidies that will apply to public programs and perhaps commercial products, the respective roles of programs like FHP and HNY in expansion and the ability of employers and individuals to “buy in” to public programs like FHP. The buy-in component in particular raises a whole second tier of issues such as constructing pools for subsidy-eligible and non-subsidy eligible populations, minimum participation rules, “slice business” and additional adverse selection and crowd-out concerns. Great care will have to be taken to limit individuals’ and employers’ ability to gain favorable terms by “selecting” the segment of the market from which they purchase, and purchasing from one market or another as their needs change. In essence, New York must decide if it will redesign the health care marketplace to create one market instead of two.

A Connector or Insurance Exchange

A strong case can be made for creating a single, harmonized market with an array of complimentary, subsidized and unsubsidized products targeted to particular income groups and perhaps the different ways populations access care. A connector or insurance exchange may be the best way to achieve an efficient, streamlined, consumer-friendly market for individuals and employer groups to purchase coverage.

In Massachusetts, the Connector is responsible for both the subsidized “Commonwealth Care” and unsubsidized “Commonwealth Choice” products. Commonwealth Care is government-subsidized private coverage that will be offered by traditional Medicaid managed care plans in the program’s first three years. The Massachusetts law also undertook a sweeping reorganization of the individual and small group markets as part of its reform. The two markets were merged into one risk pool, and the statute mandated that the Connector create a range of new, standardized products known as Commonwealth Choice.

In addition to creating the new product range, the Connector was charged with setting standards for coverage that qualifies as “creditable” towards the individual mandate, and determining the schedule of subsidies for individuals. Once the standards for creditable coverage were set, the Connector had to make difficult decisions about whether to “grandfather” existing products that did not meet the standards and the level of affordability beyond which individuals would be exempt from the mandate.

In Massachusetts, the Connector both executes state policymakers’ vision of reform and shapes it through the exercise of its broad discretionary authority. Much more than a market facilitator that makes plans available to consumers—the minimum role it could fulfill—the Massachusetts Connector regulates both industry *and* social behavior by determining subsidies, affordability, and minimum coverage standards, organizing enrollment and premium collection, and establishing Section 125 plans for employer groups. But the enacting legislation stopped short of endowing it with the duties at the far end of the spectrum: the ultimate purchaser of coverage for the uninsured.

The wide range of responsibilities of the Massachusetts Connector provides a good sense of the duties that could be assigned to a connector or insurance exchange in New York. The FHP buy-in legislation establishes a base for a New York connector by authorizing the DOH to contract with vendors to organize the purchase of FHP by employers and Taft-Hartley Trusts, and to administer subsidies. New York will have to determine if its home-grown connector will play a role in commercial markets.

Washington State has developed a purchasing entity modeled on the Massachusetts Connector, called the “Health Insurance Partnership” (HIP). As of September 2008, small businesses will be permitted to purchase coverage through the HIP and state subsidies will be available for low-income employees who purchase coverage here. The HIP board will select a minimum of four plans to be offered and will determine rates, benefits, minimum requirements, and portability.²³ California is also considering a new purchasing pool as part of its reform efforts. The pool’s authority would range from facilitator to negotiator under the Governor and legislature’s proposals.²⁴

Immediate Insurance Market Issues for New York

Irrespective of the role a connector assumes, New York’s commercial markets—especially its existing risk-pooling mechanism—require immediate attention from state policymakers. Adverse selection in the direct pay market and inadequate stop-loss subsidies have led to rapidly declining enrollment and sky-high premiums. It is simply no longer an option for most New Yorkers.

Decisions also have to be made about the role the quasi-public HNY program will play in the next stage of reform. A small group of SID staff has worked tirelessly to boost enrollment, which now reaches over 130,000 New Yorkers. But we have reached a point where some basic questions have to be raised about the proper role for HNY as we move ahead.

The most recent report on the program notes that 72 percent of enrollees had other coverage in the previous 12 months, which suggests that HNY coverage to a significant degree is replacing elements of the existing individual or small group markets.²⁵ And while HNY was designed in part to leverage employer contributions to coverage, less than one-third of HNY insured enter the program through employer groups, despite costly marketing efforts, eligibility standards that are based on salary not household income, and that, by design, can provide subsidies for three members of an employer group for each HNY-eligible member. We may have reached the limit in terms of a stop-loss-based subsidy’s ability to make products affordable enough for the employers and employees that make up the largest share of our uninsured. Questions also linger about the benefit package design, particularly given promising research about the importance of chronic disease management to overall cost control efforts²⁶ and evidence from the Brooklyn HealthWorks program that high out-of-pocket costs limit enrollment in the core HNY program.²⁷

Stepping back for a moment, it also makes sense to look at the overall dynamics of the direct pay, HNY, sole proprietor, and small group markets. As we mentioned earlier, Massachusetts merged these market segments as part of its reform efforts, and the merger of the individual and small group markets is a component of the New York State Conference of Blue Cross and Blue Shield Plans' reform proposal and has been endorsed by a number of HMOs as well.

This would seem to be an opportune time to examine the impact of merging these markets, particularly given the hodge-podge of risk adjustment mechanisms that has evolved. For example, the HNY program merges its individual, sole proprietor (both at 250% FPL), and small group (groups eligible if one-third of employees earn below \$35,600 and at least one eligible enrolls), micro-markets, and fully funds stop-loss coverage for each of these populations through the \$5,000–\$75,000 corridor. Sole proprietors may purchase direct pay coverage, HNY, or “group of one” small group coverage with a 15 percent surcharge through associations. Direct pay stop-loss reimburses at the original \$20,000–\$100,000 corridor with no income eligibility requirements, but only about 40 percent of eligible claims. As an overlay on these programs, the much-revised (and reviled in some quarters) Regulation 146 has provided “on and off again” risk adjustment subsidies to the direct pay and small group markets.

Forthcoming analysis for the United Hospital Fund will explore the impact of reforms to merge the direct pay, small group, HNY and sole proprietor/group of one markets and provide an analysis of risk mitigation programs. Our goal will be to produce an actuarial analysis of the premium impact of merging these markets through a carefully-designed study which examines claims experience and benefit values of each market segment, and the impact of the various risk mitigation mechanisms in “smoothing out” undesirable results.

The Benefits Question

Among the most difficult issues you will face—and one that affects each of the other questions you will consider—is the benefits that should come with a health insurance policy in New York. What's more, you will consider the benefits question at a time when health care cost increases have fueled a drive to change the fundamental nature of health insurance in which risks and costs are spread among large groups of insureds (who purchase benefits which they might not use so that coverage is more affordable for all), to a new system where each individual is encouraged, from year to year, to purchase only the benefits that they will need. While consumers have stressed the need for comprehensive coverage, and you have heard many witnesses testify on the

hardships of underinsurance, health plans and others have urged you to scale back benefits to make coverage more affordable. We offer no easy solutions, but some thoughts on this dilemma.

- Community rating, open enrollment, guaranteed issue and renewability, and pre-existing condition reforms have sharply curtailed medical underwriting in the New York market. But the instinct among health plans to avoid risks is a powerful one. Great care needs to be taken to curb insurers' ability to medically underwrite by tailoring benefits to avoid signing up the people who might use them.
- If you want to preserve a market where comprehensive benefits are available to individuals, you cannot rely only on those consumers who need those products to sustain comprehensive benefits packages.
- Efforts to encourage or require individuals to purchase coverage if they perceive low benefit levels or high out-of-pocket costs make it a bum deal.
- Health plans have argued for changes to existing law and regulation to allow them to offer lower benefit packages and rate them separately from more comprehensive coverage in order to bring younger, healthier risks into insurance markets. The question to ask is how does one simultaneously capture the benefit of these better risks for community pools, and at the same time drive down prices by rating them separately?
- Value-based benefits. It is also important that benefit design encourage and support preventive and essential care for chronic disease known to be effective and efficient. This includes essential medication, such as insulin to control diabetes. Research studies find that cost-sharing that discourages use of such essential, high-value care can result in higher costs due to complications and undermine health.²⁸
- If limited benefit policies are authorized, they should at a minimum include recommended preventive, essential care. Studies should also track whether such policies draw healthier, younger groups away from broader groups that span age and health conditions. Such risk segmentation undermines risk pooling and provides incentives for health plans to compete on health risk rather than quality and cost performance.
- If you decide to enhance commercial insurers' ability to offer lower-benefit packages, state policymakers should be wary of increasing cost-shifts from commercial markets to public ones.

Standardization

Each of the hearings has featured persuasive testimony from health care providers on the vast costs and time consumed by trying to deal with multiple health plans' varying rules and procedures for credentialing, prior authorization, claims submissions, benefits and other areas. The DOH and SID produced a good bill last year by convening stakeholders to deal with questions on external review, out-of-network use, timely submission of claims and other areas. A similar effort to streamline the nettlesome thicket of benefit and procedural differences among health plans seems worthwhile and something that could produce an equally good result.

Finally, two other insurance issues are worthy of further exploration, based on earlier testimony at partnership coverage hearings: COBRA subsidies and the aging off of children from their families' coverage at age 19 or 23, depending on their educational status.

On the former, patients with serious illnesses like cancer and multiple sclerosis have made a strong case for New York to look at a broad COBRA subsidy program. New York has a program (Insurance Law section 1122) on the books and has experimented with it in the past, but its focus has been on plugging episodic gaps in employer-sponsored insurance coverage due to hours worked eligibility requirements in collective bargaining agreements. Testimony from the hearings suggests that a program focused on assisting with the required COBRA premium for consumers too ill to work makes sense for number of reasons. Patients in these circumstances seem to be able to pay a portion of the premium, and maintenance of the employer-sponsored coverage promotes continuity of coverage which is often comprehensive and can provide a "bridge" to Medicare benefits due to SSI eligibility. At the same time, the state can leverage a group rate with a commitment limited to the term of COBRA eligibility.

On the aging off issue, it will be interesting to see how carriers react to the statute adopted last year which authorizes health plans to provide dependent coverage up to age 25. While you evaluate proposals to mandate such coverage and sort through the thorny issues of who will pay for it, it would seem to make sense to explore how the existing statutory rights consumers have when they are terminated from coverage are working in the market. Do young adults and their parents know of and exercise their COBRA rights under fully-insured and self-funded plans to extend coverage? Do young adults and their families know of and exercise their conversion rights under policies? Would revisions to the types of conversion policies health plans offer make conversion a more attractive option to young consumers? These are all questions that merit further consideration.

Mandates

Research findings and lessons from other states that demonstrate the limits of voluntary coverage expansions. Three recent micro-simulation modeling exercises for New York and Massachusetts, including *Blueprint*, have demonstrated that voluntary coverage expansions will enroll only about one-third of the uninsured and that the cost per newly insured under voluntary expansions will be relatively high because sicker people are more likely to take up coverage on a voluntary basis.²⁹

A wide body of research has explored the potential of premium subsidies toward employers and individuals to see what effect they would have on participation rates and ultimately on reducing the number of uninsured. A review of the literature on the “price elasticity” of demand for discounted non-group insurance prepared by Gorman et. al. concludes that reducing the price of insurance has only a modest effect on demand, inducing only a small number of uninsured persons to purchase coverage voluntarily. Most studies estimate a price elasticity of -0.3 to -0.7 , which means that a 10 percent reduction in the cost of coverage would lead to a 3 percent to 7 percent increase in the number of people purchasing insurance. Studies suggest that even sizable premium discounts, such as between 50 percent and 60 percent, would induce no more than a quarter of uninsured persons to purchase coverage.³⁰

Lessons from other state experiences are also instructive with regard to the relative limits of voluntary coverage expansions. Enacted in 2003, Maine’s Dirigo Health plan, a comprehensive voluntary health reform initiative that intended to cover all uninsured state residents, had enrolled only 19 percent of its target population by March 2007.³¹ Further, Ku and Coughlin examined the experience in four states’ subsidized insurance programs and found that participation rates decline as premiums consume an increasing share of income and that even among lower-income persons with relatively low premium requirements (e.g., the median premium for a two-person family represented 1%–5% of income for persons with income below 200% of FPL), no more than 55 percent of uninsured persons participate.³² Finally, reviews of a variety of state and local initiatives to expand employer-based coverage find relatively limited enrollment.³³

Furthermore, *Blueprint* modeling also revealed that employer mandates alone will not achieve universal coverage. This is because not all employers will offer coverage (under a “pay-or-play” scenario, some employers will opt to pay the assessment), not all workers will take-up employer coverage offers, and not all uninsured are workers. Employers can play an important role in contributing toward the financing of coverage expansion, but ultimately an individual mandate is necessary to achieve universal coverage. As such, states are increasingly considering coverage mandates—on employers

and individuals—as a means of enrolling a greater number of uninsured persons and raising revenues to finance the expansion.

Employer Assessment

The state must determine whether employers should be required to contribute financially toward a coverage expansion, and whether any employers—such as small or low-wage employers—should be exempt from an employer assessment.³⁴ And if an employer contribution is required, whether it should be a nominal contribution (e.g., equivalent to the amount that insuring employers spend on uncompensated care for uninsured workers, approximately \$400/worker/year), or if it should approximate the cost of coverage insuring employers now pay (approximately \$3,600/worker/year).

Massachusetts and Vermont have enacted modest employer assessments (\$295 and \$365 per worker per year, respectively) while California and Pennsylvania have proposed higher assessments (proposals in California range from 0%–4% and 2%–6.5% of payroll assessment while Pennsylvania has proposed a 3% of payroll assessment). In Massachusetts firms with fewer than 11 employees are exempt from the employer assessment. Similarly, Vermont’s employer assessment excludes the first eight employees in years one and two, the first six employees in year three, and the first four employees thereafter. Proposals in California include a sliding scale assessment based on the payroll size of the firm. Pennsylvania’s proposal would exempt the first 50 employees from the assessment in the first year.

It is also important to consider the impact of the allocation of resources across payers at start-up and over time. For example, some have suggested that Massachusetts’ “modest” employer assessment may need to be reevaluated over time if federal or state revenues decline or if premium growth continues to exceed other factors in the economy.

ERISA, the Employee Retirement Income Security Act of 1974, constrains states’ ability to impose coverage requirements on employers. A state can impose a tax but cannot require employers to offer coverage. A “pay-or-play” design whereby employers are taxed, but receive a credit for the value of coverage provided, is most likely to withstand an ERISA challenge. As described in work by Patricia Butler, the 2006 Fourth Circuit Court of Appeals *RILA v. Fielder* decision provides several lessons for states considering a pay-or-play approach:

- The tax should look like a tax, not a coverage mandate.
- The tax should apply to a large number of employers.

- The state should consider setting the tax rate low enough that it does not affect most employers who currently provide coverage.
- The state should define employer spending that is eligible for a credit from the tax broadly enough that employers face a real choice between paying the tax and increasing the amount spent on health care for their workers.
- The purpose of the tax should be to raise revenues to fund a broad-based public program. Program eligibility should not be contingent upon an employer's payment of the tax.³⁵

Proposals in California and Pennsylvania that include higher employer assessments will have to be carefully constructed or these will face ERISA challenges.³⁶ As mentioned above, health care reform proposals in California include employer assessments ranging from 0 percent–4 percent of payroll under the Governor Schwarzenegger's proposal to 2 percent–6.5 percent under the legislature's "compromise" proposal. Pennsylvania Governor Rendell's proposal would impose a 3 percent of payroll assessment on non-offering employers.

Individual Mandate

Research indicates that an individual mandate is necessary to achieve universal coverage.³⁷ As such, many recent state reform initiatives have included this feature. In addition to Massachusetts where the mandate only applies to adults with access to affordable coverage, proposals in California and Pennsylvania also include individual mandates subject to certain limits. The California legislature's "compromise" proposal includes an affordability provision (persons are exempt if coverage costs more than 6.5% of income) and Pennsylvania's individual mandate would only apply to persons with income above 300 percent FPL. Further, both Maine and Vermont have indicated that they will consider individual mandates if their voluntary efforts do not achieve near-universal coverage.

It is important that a coverage mandate be imposed on a strong base of public and private coverage. As such, this should be the final element of a phased reform effort. Before imposing a mandate, public programs should function well so that it is relatively easy for eligible persons to enroll in and retain coverage. It is also essential that affordable coverage options are available to New Yorkers who are not eligible for fully subsidized coverage. If voluntary measures do not yield significant take-up, an individual mandate would capture a significant share of low-income persons.

Three fundamental questions must be answered with regard to an individual mandate:

- 1) What level of coverage will the state mandate residents to have?

- 2) What will individuals be required to contribute toward coverage?
- 3) How will the mandate be enforced?

The decisions regarding the level of coverage and contributions required tie back to the discussion of affordability. The state must balance the desire for comprehensive coverage with the desire for affordability for all. With regard to enforcement of the mandate, the most likely route is through the state tax system. A section could be added to the tax form that allows residents to document their coverage status and those who are not covered can be assessed a penalty for non-compliance. Indeed, this is how Massachusetts will enforce its mandate in beginning in 2008.

Research suggests that an individual mandate increases the demand for employer coverage because if required to have coverage, many workers prefer this form of coverage. As a result, an individual mandate may raise ERISA concerns if it can be argued that the mandate influences employers to modify their plans.

Cost Containment

There are many factors that increase health care costs without providing value, but states have had limited success in reducing costs or moderating statewide trends over time. Further, addressing cost trends in any state will likely require concerted and coordinated efforts across federal and state public programs as well as private insurance payers. The federal government through Medicare accounts for one-fifth of all health care spending, and an even higher share of specialists and hospitals that care for acute and chronic health conditions that are concentrated among elderly and disabled patients.³⁸ Medicare provider payment rates, methods, and policies thus directly influence New York's health care markets. Moreover, federal-state coordination is important because if a state were to make changes beyond or absent changes at the federal level, health professionals could leave the state if these policies were undesirable.

That said, there are a number of cost control strategies that a state can consider. These focus on factors amenable to health policy that contribute to high or rising levels of expenditures without value in terms of access, quality, or health outcomes (Figure 3).³⁹ Controlling both baseline expenditures (by reducing waste, costs of care due to safety gaps, and inefficient care) and the rate of increase (by enhancing information on effective and efficient care, addressing population health, and realigning incentives to promote high quality and efficient care) will yield substantial gains over time. These strategies include investing in New York's primary care and health information system capacity to deliver accessible, safe, high quality, efficient, and patient-centered care (Figure 3).

Figure 3. Why Are U.S. Health Care Expenditures High and Increasing More Rapidly than Incomes?

- National health spending expected to double over next 10 years— from \$2 trillion to \$4 trillion, rising from 16% to 20% of GDP
- New York has followed national trends
- Factors contributing to high and increasing costs without value (inefficient care)
 - **Overuse, inappropriate use, duplication or ineffective care**
 - **Access barriers, lack of prevention, complications of disease**
 - **Payment and pricing incentives that reward doing more without consideration of value or quality/outcomes**
 - **Weak and undervalued primary care (vs. specialized care)**
 - **Inadequate information systems and information on what works**
 - **Poor care coordination**
 - **Safety concerns: adverse drug events, infections, etc.**
 - **High overhead costs: insurance administrative complexity**
- Factors contributing to long-term trends—amenable to policy
 - **New technologies without comparative information on clinical or cost effectiveness to guide decisions about adoption**
 - **Rising rates of chronic disease—public health**
 - **Few leverage points to encourage more efficient care**

Primary care can provide an essential foundation for high quality, lower cost care if organized with financial support to be accessible (including after-hours) and with teams and information systems capable of coordinating and managing care as patients move across sites of care. Information systems with decision support for physicians and other caregivers and the capacity of exchange with information following patients, provides a basic tool to enable more integrated, safe and efficient care with a focus on health care outcomes.

More generally strategies to lower and slow the growth of health expenditures over time cluster into five conceptual areas, each associated with multiple potential policies:

- 1) Better information: health information technology, information on clinical and cost effectiveness, patient information and decision aids, transparency
- 2) Incentives aligned with health system quality and efficiency: support of primary care, care coordination, and management
- 3) Correcting pricing signals to markets and lower administrative overhead
- 4) Public health, disease management, and preventive care
- 5) Insurance coverage designed to enable access and support coherent, more integrated “system” approaches to high quality, efficient care

Targeted policies within the areas listed above that address baseline expenditures include:

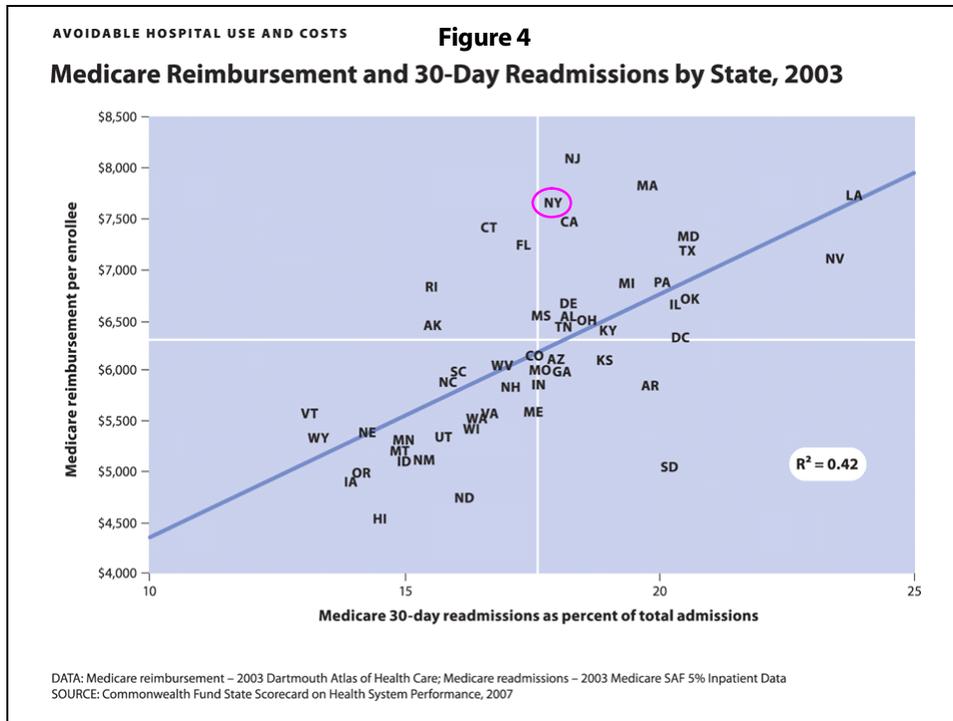
- Implementing electronic records, with decision support
- Payment systems that support and enhance primary care capacity to provide after-hours care, coordinate care, and engage patients to promote health
- Chronic illness care management programs
- Process improvement in clinical operations
- End-of-life care
- Malpractice reform
- Drug pricing reform
- Transparency with information on quality and costs
- Reduction of administrative overhead

Approaches to reducing the rate of cost growth include:

- Public health and prevention initiatives
- Payment reform, such as capitation or pay-for-performance
- Establishing effectiveness review for new drugs and technology
- Electronic records, with decision support and exchange across sites of care
- Limiting growth in capital expenditures

The state can use public purchasing power to influence more efficient care. This can include Medicaid and the state employees' plan. It could also include a new insurance connector, as described above. The state should strive to reduce administrative complexity in each of these systems. The state could also collaborate with other major New York payer groups, such as New York City employees and the New York Business Group on Health, to address areas of shared concern with coordinated policies and incentives.

Further, New York can tailor its strategies to areas in which costs are identified to be high relative to other states (see The Commonwealth Fund's "State Scorecard").⁴⁰ For example, New York has among the highest rates of 30-day hospital readmissions in the country (Figure 4). Such readmissions drive up costs and put patients at risk. The high rate of readmissions signals gaps in follow-up care after discharge, a weak primary care base, and potentially high complications during hospital stays.



Similarly, New York has relatively high rates of admissions to hospitals for potentially preventable complications of chronic disease. With a focus on chronic conditions, research by Drs. Ken Thorpe and John Billings presented at a recent United Hospital Fund roundtable describe two approaches to achieving cost savings in New York. Dr. Thorpe analyzed the top 15 conditions that are driving health spending in New York and concludes that many of the most expensive conditions are due to lifestyle and obesity (e.g., diabetes, hypertension, and heart disease). Further, a significant share of costs associated with these conditions are due to the increased prevalence of treated disease, not the increased cost of treatment. He suggests that savings could be achieved over the long-term through focus on population health and disease prevention, as well as chronic care management. The state could consider the New York City Department of Health and Mental Hygiene’s anti-smoking, obesity, and public health campaigns as potential models for statewide initiatives.

Dr. Billings presented his analysis of Medicaid high cost claims data and indicates that a significant share of Medicaid’s costs are due to avoidable, or primary care-treatable, hospitalizations.⁴¹ He has designed an algorithm to predict high cost Medicaid cases based on patients’ utilization and diagnostic histories and suggests that the state can realize savings by targeting interventions to avoid a share of their future hospitalizations. Several New York City hospitals are participating in a United Hospital Fund-led initiative that uses this analysis to redesign service delivery for their high cost Medicaid cases. Furthermore,

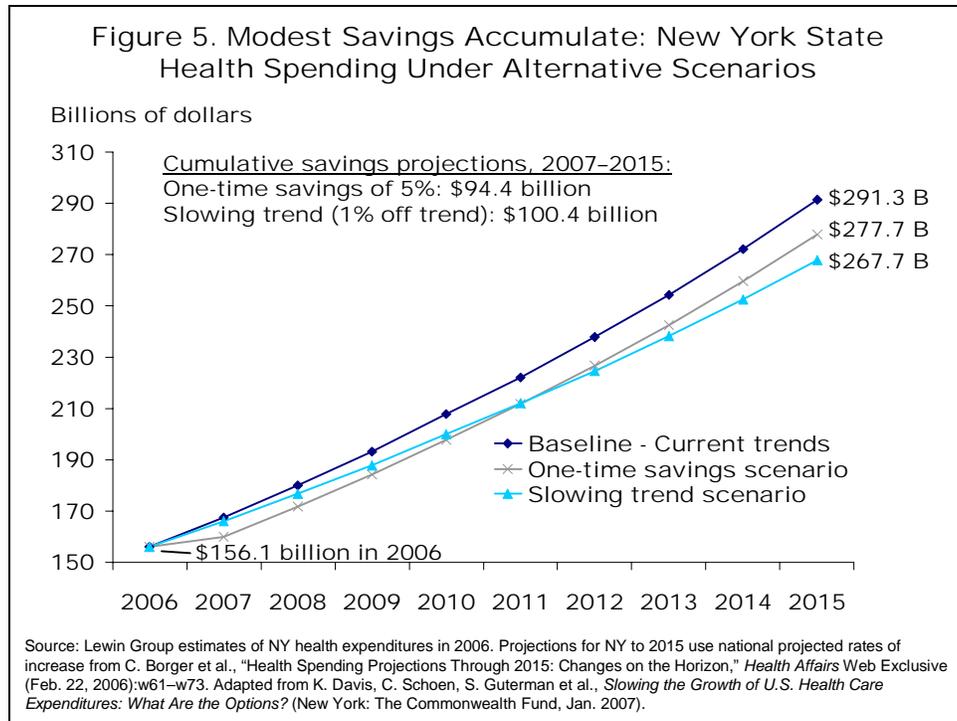
pointing to the need for a “system” approach, New York’s Medicare hospitalization rates are also high for admission of “ambulatory care sensitive” or potentially avoidable complications from chronic conditions.

The Massachusetts health reform did not include an aggressive cost containment effort. Instead, the law established a “Cost and Quality Control Council” which will set cost and quality goals for the state, establish performance benchmarks, and publish information for consumers to use in making medical decisions. The Council is now examining areas and “efficiency indicators,” such as hospital readmissions, where Massachusetts rates are high to explore the potential for coordination initiatives.

In its health care reform effort, Vermont is focusing on chronic disease with a statewide initiative for a healthier Vermont. Pennsylvania’s proposal includes policies aimed at improving after-hours care to lower expensive/avoidable visits to hospital emergency rooms and changes to the scope of practice to enable expanded primary care capacity and teams.

While there is promise in this area, to date there has been limited evidence of cost containment initiatives realizing significant savings. Notably, all efforts thus far have occurred in the context of an insurance system with major gaps in coverage and high rates of “churning.” This structure encourages and enables “cost-shifting” across payers and puts the uninsured at high risk—including prices well above those charged to insured patients. Frequent churning on and off of coverage and across plans increases administrative costs and undermines incentives for health plans to make long-term investments in patients’ health that will accrue over multiple years. Viewed on a population-wide basis, fragmented insurance also undercuts leverage points and makes it more difficult to achieve system savings and improve value. As such, we believe that well-designed coverage expansions are critical to addressing short and longer term cost trends. In other words, we need a “system” approach that includes coverage expansion as well as a multi-faceted set of policies that focus on costs, efficiency, and value. At the same time, maintaining universal coverage will require a focus on costs because it will otherwise be unsustainable.

The challenge will be building consensus. Significant savings are possible with improved access, quality, and health outcomes. Comparing projected total health spending, assuming New York follows federal trends, even small reductions in the future level or rate of growth add up to substantial cumulative dollars over time (Figure 5). But with all cost containment initiatives, it is important to remember that one payer’s expenditure is another’s income and thus these efforts will generate political controversy. Reaching consensus will require a focus on the potential shared gains for all of New York: families, businesses, and public sectors.



Financing

A key lesson from the *Blueprint* is that a straight expansion of public coverage without any requirement of employers (an assessment or other disincentive to drop coverage) puts a significant financial burden on the state. Under the “public program changes” scenario we modeled (which includes changes to public programs but does not include an individual or employer mandate), 840,000 persons would be newly insured at an estimated cost to the state of \$4.8 billion, while employers would save an estimated \$4.4 billion. The *Blueprint* results also indicate that, depending upon the level of employer assessment required, universal coverage can be achieved at an estimated cost to the state of \$4 billion to \$5.5 billion, under the “higher” and “modest” employer assessment scenarios, respectively.⁴²

States have financed or propose to finance their coverage expansions through a variety of sources, as described below:

- Massachusetts
 - A modest employer assessment (\$295/worker/year if an employer does not make a “fair and reasonable contribution” toward its employees’ coverage);
 - Individual payments for private insurance (alternatively, “penalty payments” if individuals do not comply with the mandate);

- Redirecting existing funds from the state’s uncompensated care pool;
- Additional federal matching funds; and
- State general revenue.
- Maine
 - Employer premium contributions (employers who choose to participate must pay 60% of employees’ premiums);
 - Individual premium contributions;
 - Insurer “savings offset payment” of up to 4 percent of gross revenues. (Payment is determined based on the savings documented as a result of the Dirigo health reform, including reductions in charity care as a result of declining uninsured rates.);
 - Tobacco settlement fund allocations;
 - Federal matching funds; and
 - State general revenue.
- Vermont
 - A modest employer assessment (\$365/ worker/year if an employer does not offer coverage or its employees are uninsured);
 - Individual premium contributions;
 - Revenues from increased cigarette and tobacco taxes;
 - Federal matching payments; and
 - State general revenues (though enrollment will be capped in order to limit state obligations).
- California (proposals)
 - Employer assessment (ranging from 0%–4% [Governor] to 2%–6.5% [legislative compromise] of payroll);
 - Individual and employee premium contributions;
 - Hospital fee;
 - Redirection of safety net (county) funds;
 - Federal funds;
 - Other revenues: leasing the state lottery (Governor) and increased tobacco tax (legislative compromise).

- Pennsylvania (proposal)
 - Employer assessment (3% of payroll);
 - Individual and employee premium contributions;
 - Taxes on smokeless tobacco, cigars, and increase in cigarette tax;
 - Federal funds;
 - Redirection of spending on “AdultBasic” (state-subsidized insurance coverage), uncompensated care, and the community reinvestment fund.

New York will likely have to consider a similar combination of financing sources, but should not underestimate the complexity of the politics associated with each.

SUMMARY

A critical initial question is whether or not to build on the existing system or to pursue more dramatic restructuring options. We advocate building upon the strengths, and accepting the complexities, of the existing system and outline a set of issues to consider if pursuing such an approach to universal coverage.

- Forty percent of New York’s uninsured are eligible for public coverage but not enrolled; another 38 percent are low-to-moderate income but are not eligible for public coverage. Consider building on existing **public programs** through further simplification reform and eligibility expansion, both to increase participation rates among the currently eligible but uninsured and to extend coverage to more low- to moderate-income New Yorkers.
- Consider reforms to the **private insurance markets** that will both support coverage expansion efforts and better serve New Yorkers in these markets in the short term.
 - In the context of broader reform, New York must decide whether it will maintain its current system in which public and private markets are operated and regulated separately by different agencies and under different rules or whether it can bring these markets together in some fashion.
 - Consider an insurance “connector” or “exchange,” which may be the best way to achieve an efficient, streamlined, and consumer-friendly market for individuals and employer groups to purchase coverage. A connector’s potential roles range from a facilitator that makes plans available to consumers to the purchaser of coverage for the uninsured.

- Among the most difficult issues you will face—and one that affects each of the other questions you will consider—is the benefits that should come with a health insurance policy in New York. Issues to consider include:
 - Great care needs to be taken to curb insurers’ ability to medically underwrite by tailoring benefits to avoid signing up the people who might use them.
 - If you want to preserve a market where comprehensive benefits are available to individuals, you cannot rely only on those consumers who need those products to sustain them.
 - If bare bones policies are authorized, they should at a minimum include recommended preventive, essential care. Studies should also track whether risk segmentation occurs because it undermines risk pooling and provides incentives for health plans to compete on health risk rather than quality and cost performance.
 - If you decide to enhance commercial insurers’ ability to offer lower-benefit packages, state policymakers should be wary of increasing cost-shifts from commercial to public markets.
- The state should also consider a number of short-term issues in the private insurance market:
 - Adverse selection in the direct pay market and inadequate stop-loss subsidies have led to rapidly declining enrollment and sky-high premiums, such that it is simply no longer an option for most New Yorkers.
 - Examine the impact of merging the direct pay, Healthy New York, sole proprietor, and small group markets, particularly given the range of risk adjustment mechanisms that have evolved.
- Consider **coverage mandates** given the demonstrated limits of voluntary initiatives to achieve universal coverage.
- Employer “mandates” alone will not achieve universal coverage but can play an important role contributing to the financing of an expansion. Consider:
 - Whether employers should be required to contribute financially toward a coverage expansion, and if so, whether it should be a nominal contribution or if it should approximate the cost of coverage;

- Whether any employers—such as small or low-wage employers—should be exempt from an employer assessment.
- Research indicates that an individual mandate is necessary to achieve universal coverage. Three fundamental questions must be answered with regard to an individual mandate:
 - 1) What level of coverage will the state mandate residents to have?
 - 2) What will individuals be required to contribute toward coverage?
 - 3) How will the mandate be enforced?
- It is important that a coverage mandate is imposed on a strong base of public and private coverage; as such, this should be the final element of a phased reform. Public programs should function well so it is relatively easy for eligible persons to enroll and retain coverage. And, affordable coverage options must be available before a mandate is imposed. Defining what is “affordable”—both an economic and political exercise—is a critical component of reform.
- There are a number of **cost control strategies** that a state can consider, that focus on factors amenable to health policy that contribute to high or rising levels of expenditures without value in terms of access, quality, or health outcomes.
- Controlling both baseline expenditures and the rate of increase will yield substantial gains over time.
- Targeted policies that address baseline expenditures include:
 - Implementing electronic records, with decision support
 - Payment systems that support and enhance primary care capacity to provide after-hours care, coordinate care, and engage patients to promote health
 - Chronic illness care management programs
 - Process improvement in clinical operations
 - End-of-life care
 - Malpractice reform
 - Drug pricing reform
 - Transparency with information on quality and costs
 - Reduction of administrative overhead

- Approaches to reducing the rate of cost growth include:
 - Public health and prevention initiatives
 - Payment reform, such as capitation or pay-for-performance
 - Establishing effectiveness review for new drugs and technology
 - Electronic records, with decision support and exchange across sites of care
 - Limiting growth in capital expenditures
- While there is promise in this area, to date there has been limited evidence of cost containment initiatives realizing significant savings. However, all efforts thus far have occurred in the context of an insurance system with major gaps in coverage and high rates of “churning.” We believe that well-designed coverage expansions are critical to addressing short and longer term cost trends and at the same time recognize that universal coverage cannot be sustained without a focus on cost control.
- We think there should be shared responsibility for **financing** the expansion across government, employers, and individuals. New York can look to the experience in other states regarding the variety of funding sources used:
 - Employer assessments;
 - Individual premium contributions;
 - Redirecting existing funds;
 - Revenues from increased cigarette and tobacco taxes;
 - Additional federal matching funds; and
 - State general revenue.

Finally, two issues that are beyond the scope of this testimony but will require resolution over the long-term are:

- What will be needed from the federal government, including waiver provisions and level of financial support.
- Clarification of how immigration status may affect individual participation in reform efforts.

NOTES

¹ United Hospital Fund analysis of tabulations of the 2001–2006 *Current Population Survey Annual Social and Economic Survey*, prepared by the Urban Institute for the United Hospital Fund.

² United Hospital Fund analysis of county-level New York State Insurance Department standardized health plan premium data. Data accessed at <http://www.ins.state.ny.us/ihmoindx.htm>.

³ A United Hospital Fund study found that, in 2001, 42% of children in Child Health Plus B were disenrolled at renewal, and that two-thirds who did not renew coverage in 2001 were enrolled a year later. See M. Birnbaum and D. Holahan, *Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences* (New York: United Hospital Fund, 2003). Another study from The Commonwealth Fund found that 93% of children remain eligible for Child Health Plus B coverage at the time of recertification, despite the fact that the disenrollment rate is approximately 50%. See K. Lipson, E. Fishman, P. Boozang et al., [Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs](#) (New York: The Commonwealth Fund, Aug. 2003.)

⁴ A. Cook, D. Miller, and D. Holahan, "Health Insurance Coverage in New York: 2004–2005" (United Hospital Fund–Urban Institute, Sept. 2007). Data are for 2004–2005.

⁵ United Hospital Fund, "New York's Eligible but Uninsured," forthcoming.

⁶ S. R. Collins, C. Schoen, K. Davis, A. K. Gauthier, and S. C. Schoenbaum, [A Roadmap to Health Insurance for All: Principles for Reform](#) (New York: The Commonwealth Fund Commission on a High Performance Health System, Oct. 2007).

⁷ R. R. Bovbjerg, S. Dorn, J. Hadley et al., *Caring for the Uninsured in New York: What Does It Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?* (Washington, D.C.: Urban Institute, Oct. 2006); Lewin Group, [Estimates of the Cost and Coverage Impacts of Proposals to Expand Health Insurance Coverage in New York](#) (Falls Church, Va.: Lewin Group, Dec. 2006); M. Birnbaum, *Medicaid Coverage for Adults in New York, 2001–2003: Trends and Policy Implications* (New York: United Hospital Fund, June 2006); and M. Birnbaum, K. Haslanger, J. Billings et al., *Estimating the Cost of Enrolling New York City's Eligible but Uninsured Adults in Medicaid* (New York: United Hospital Fund, 2004).

⁸ D. Holahan, E. Hubert, and C. Schoen, [A Blueprint for Universal Health Insurance Coverage in New York](#) (New York: United Hospital Fund–Commonwealth Fund, Dec. 2006).

⁹ S. Dorn and G. M. Kenney, [Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers](#) (New York: The Commonwealth Fund, June 2006).

¹⁰ L. Summer and C. Mann, [Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies](#) (New York: The Commonwealth Fund, June 2006).

¹¹ Forthcoming analyses by the United Hospital Fund and by Manatt, Phelps, Phillips, LLP and Health Management Associates for the United Hospital Fund are expected in late 2007/early 2008.

¹² The federal poverty level is \$10,210 for an individual and \$17,170 for a family of three in 2007; 150% FPL is \$15,315 for an individual and \$25,755 for a family of three in 2007.

¹³ J. Gruber, "Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance" (Cambridge, Mass.: Massachusetts Institute of Technology, Mar. 2007). Note that this analysis considered premium levels established for Massachusetts Insurance Connector plans of approximately \$200–\$300 per month.

¹⁴ See L. J. Blumberg, J. Holahan, J. Hadley et al., “Setting a Standard of Affordability for Health Insurance Coverage,” *Health Affairs* Web Exclusive (June 4, 2007):w463–w473.

¹⁵ Note that 13.2% of income reflects the share of income spent on the full cost (employer and employee shares) of employer sponsored insurance. Shares cited above do not sum to total because of rounding. The analysis also considers spending for non-group coverage and the employee share of employer-sponsored insurance.

¹⁶ Massachusetts’ affordability schedule explicitly refers to premiums, but did also take into account the level of other out-of-pocket spending that would be required (Jonathan Gruber, June 15, 2007). The affordability schedule shown above refers to the share of income required for individuals. For example, the maximum monthly premium required of an individual with income at 250% FPL (\$25,525) is \$70. Similarly, for a family of three with income at 250% FPL (\$42,925), the maximum monthly premium required is \$140. See <http://www.mahealthconnector.org>.

¹⁷ See Maine Health Access Foundation, “Health Reform in Maine, Massachusetts, and Vermont: An Experimentation of State Strategies to Improve Access to Affordable, Quality Care” (Augusta, Maine: MeHAF, Mar. 2007); <http://www.calhealthreform.org>; and <http://www.governor.state.pa.us> for a discussion of reforms in these states.

¹⁸ According to the Division of Health Care Finance and Policy 2006 household survey of Massachusetts residents, there are an estimated 372,000 uninsured persons in Massachusetts, or 6% of the state’s population. Other surveys indicate a higher number of uninsured persons; for example the Current Population Survey estimated that there were 647,000 uninsured persons, or 12% of the population, in 2004–2005.

¹⁹ “The Dirigo Health Reform Act: A Work in Progress” (Portland, Maine: University of Southern Maine, Muskie School of Public Service, Nov. 2007).

²⁰ “2006 Health Care Reform Initiatives: The Details” at www.leg.state.vt.us. Note that this refers to subsidies toward the state’s new subsidized coverage program, Catamount Health, not the premium assistance program.

²¹ C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren. “[Insured But Not Protected: How Many Adults Are Underinsured?](#)” *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

²² Urban Institute analysis of a merged file of the 2005 February and March Current Population Surveys, prepared for the United Hospital Fund, 2007.

²³ T. Alteras and S. Silow-Carroll, “[States in Action: A Bimonthly Look at Innovations in Health Policy](#)” (New York: The Commonwealth Fund, July/Aug. 2007).

²⁴ California HealthCare Foundation at <http://www.calhealthreform.org/>.

²⁵ EP&P Consulting, “Report on the Healthy NY Program 2006” (Washington, D.C.: EP&P Consulting, Jan. 2007).

²⁶ K. E. Thorpe, “What Accounts for the Rise in NYS Spending?” presentation at United Hospital Fund policy roundtable meeting on Nov. 15, 2007.

²⁷ Conversations with Brooklyn HealthWorks administrators, 2007.

²⁸ J. Hsu, M. Price, J. Huang et. al., “Unintended Consequences of Caps on Medicare Drug Benefits,” *New England Journal of Medicine*, June 1, 2006 354(22):2349–59.

²⁹ Holahan, Hubert, Schoen, *Blueprint*, 2006; J. Holahan, L. J. Blumberg, A. Weil et al., *Roadmap to Coverage: Synthesis of Findings* (Washington, D.C.: Urban Institute, Oct. 2005); and J. Gruber, “The Massachusetts Health Care Revolution: A Local Start for Universal Access,” *Hastings Center Report*, Sept.–Oct. 2006 36(5):14–19.

³⁰ B. Gorman, D. Gorman, E. Kilbreth et al., *Reform Options for Maine's Individual Health Insurance Market* (Portland, Maine: University of Southern Maine, Muskie School of Public Service, May 2007).

³¹ MeHAF, "Health Reform in Maine," 2007; and www.dirigohealth.maine.gov.

³² L. Ku and T. A. Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, Winter 1999/2000 36(4):471–80; and L. Ku and T. A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington, D.C.: Urban Institute, Mar. 1997).

³³ D. Chollet and L. Taylor, *A Compendium of State and Local Initiatives to Expand or Retain Employer-Based Coverage* (Princeton, N.J.: Mathematica Policy Research, Inc., Nov. 2005); S. Silow-Carroll, E. K. Waldman, and J. A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (New York: The Commonwealth Fund, Feb. 2001); and S. Silow-Carroll and T. Alteras, *Stretching State Health Care Dollars: Building on Employer-Based Coverage* (New York: The Commonwealth Fund, Oct. 2004).

³⁴ It has been noted that the burden of an employer assessment ultimately falls to low-wage workers who comprise the bulk of the uninsured. For this reason, some argue that employer "mandates" are regressive.

³⁵ See P. A. Butler, *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision* (Washington, D.C., and Portland, Maine: AcademyHealth and National Academy for State Health Policy, Nov. 2006); and P. A. Butler, *ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act"* (Washington, D.C., and Portland, Maine: AcademyHealth and National Academy for State Health Policy, Feb. 2007).

³⁶ See California HealthCare Foundation at <http://www.calhealthreform.org/> and California Chamber of Commerce at <http://www.calchamber.com>; see Pennsylvania Governor Rendell's proposal at <http://www.ohcr.state.pa.us/> and National Federation of Independent Business–Pennsylvania at <http://www.nfib.com/page/homePA.html>.

³⁷ See Holahan, Hubert, Schoen, *Blueprint*, 2006; Holahan, Blumberg, Weil et al., *Roadmap to Coverage*, 2005; and J. Gruber, "Massachusetts Health Care Revolution," 2006.

³⁸ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

³⁹ K. Davis, C. Schoen, S. Guterman et al., *Slowing the Growth of U.S. Health Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan, 2007).

⁴⁰ J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund Commission on a High Performance Health System, June 2007).

⁴¹ J. Billings and T. Mijanovich, "Improving the Management of Care for High-Cost Medicaid Patients," *Health Affairs*, Nov./Dec. 2007 26(6):1643–55.

⁴² Holahan, Hubert, Schoen, *Blueprint*, 2006.