

Analysis of Five Health Insurance Options for New York State

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Project Sponsorship



This report is part of the “Improving the Analysis of Health Insurance Expansion Options for New York State” project of Columbia University’s Mailman School of Public Health. The project’s overarching purpose is to analyze, both qualitatively and quantitatively, options to expand health insurance coverage in New York State.

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Executive Summary

In this report, we present cost and coverage estimates of five different options for expanding health insurance in New York State. For each of the five options, we estimate the following:

- Increase in coverage due to the expansion (reduction in uninsured)
- Crowd-out (the number of people with employer-sponsored or individual, non-group coverage that switch into public coverage)
- Net cost to the New York State government (the additional amount that New York State would have to pay to finance the new enrollees)
- Net change in statewide health spending (the total aggregate amount that would be spent on health care in the State less the amount that would have been spent without the expansion. This includes costs to government, employers and individual out-of-pocket expenses).

The first option we modeled was a single-payer program based on a proposal by the Physicians for a National Health Plan Program—New York Metro Chapter. The single payer program would replace all current insurers in New York with one, publicly financed system and provide comprehensive coverage to all residents of the State with no cost-sharing or deductibles. We estimate that extending such coverage to all New York State residents (including the 2.6 million uninsured) would result in a net increase in overall health care spending of \$5.8 billion primarily due to the increased generosity of coverage for those already insured as well as coverage of all the currently uninsured. To provide this coverage, New York State would have to generate about \$66.8 billion through taxes on individuals and employers. The taxes would be offset by the redirection of current employer contributions as well as substantial reductions in individual out-of-pocket payments, totaling approximately \$61 billion.

The second, third and fourth options are each “building block” proposals, which combine a series of incremental strategies for expansion. The first (“Building Block 1”) is based on the United Hospital Fund and The Commonwealth Fund’s “A Blueprint for Universal Health Insurance Coverage in New York.” The second variation (“Building Block 2”) is a slightly more generous version of the first. The third variation (“Building Block 3”) is based on the Community Service Society’s “Cornerstone for Coverage” plan. Building Block 1 and Building Block 2 combine a series of public program expansions with an individual buy-in and an option of an individual mandate. Building Block 3 provides universal access to public health insurance through expansion of the State’s Family Health Plus and Child Health Plus programs and implementation of a Family Health Plus Employer Buy-In.

Without a mandate, the first variation would cover 500,000 uninsured with an additional 300,000 who would switch from private to public coverage (crowd-out) at a cost to the government of New York State of \$1.0 billion. With a mandate, this first proposal would cover a total of 2.1 million uninsured persons at a government cost of \$4.0 billion. The second variation would cover 700,000 uninsured and an additional 400,000 of those who previously held private coverage at a cost of \$1.9 billion to New York State. Combining this second variation with an individual mandate would cover a total of 2.3 million uninsured at a cost to New York State of \$5.2 billion. The third variation would cover 1.0 million uninsured, while 500,000 would switch from private to public coverage at a cost to New York State of \$3.6 billion. With a mandate,

overall health spending in New York State under the first variation would increase by approximately \$5.0 billion and increase by \$5.2 billion under the second variation. Under the third variation, overall health spending in New York State would increase by approximately \$1.6 billion.

The last option we modeled was a market-oriented option, with elements based on the Manhattan Institute’s “Rx NY” proposal. Under the plan, approximately 100,000 – 130,000 uninsured persons would gain coverage at a cost to New York State of \$130 million and an additional cost to the federal government of \$580 million. Under this option, overall health care spending in New York State would increase by approximately \$280 – \$440 million.

**Table I:
Estimated Cost and Coverage Impacts for All Five Options***

Total Covered Through Plan (Thousands)	Reduction in Number Uninsured (Thousands)	Crowd-Out of Private Insurance (Thousands)	Remaining Uninsured (Thousands)	Net Additional State Gov’t Cost ^c (Millions)	Net Increase in Health Spending ^d (Millions)
Single Payer					
19,000 ^b	2,600	11,300	0	\$66,800	\$5,800
Building Block Variation 1					
Without Mandate					
800	500	300	2,100	\$1,000	\$900
With Mandate					
2,400	2,100	300	500	\$4,000	\$5,000
Building Block Variation 2					
Without Mandate					
1,100	700	400	1,900	\$1,900	\$1,000
With Mandate					
2,700	2,300	400	300	\$5,200	\$5,200
Building Block Variation 3					
1,500	1,000	500	1,600	\$3,600	\$1,600
Market-Oriented					
100-130	100-130	0	2,500	\$130	\$280-\$440

* Estimates may not sum due to rounding.

^a Total covered through plan represents all the individuals who will enroll in some form of insurance as a result of enacting this plan. This includes the uninsured who become newly insured as well as individuals already covered by private insurance (employer or individual) and would now switch to this new coverage (crowd-out).

^b The single payer system replaces all existing insurance programs. Therefore, all people with private insurance would be covered under single payer. In addition, columns 2 and 3 do not sum to column 1 because the “total covered through plan” also includes all people previously on public insurance (Medicare, Medicaid, etc.) now part of the single payer plan.

^c The net additional government cost represents the additional amount of money the New York State government will have to contribute in order to finance the plan.

^d The net increase in health spending represents the change in overall health spending that will result from the enactment of the plan. It is calculated as the sum of all health expenditures (government, private, and out-of-pocket and administration) after the plan is enacted minus current level of health expenditures. Most of this increase is spending comes from individuals who were previously uninsured and took up either private or public coverage and thus would now have greater health spending.

Our analysis shows that no single approach clearly dominates the others. We conclude that any insurance expansion in New York State will involve tradeoffs of numbers covered, costs, generosity and comprehensiveness of coverage. By providing a reference of the broad implications and tradeoffs of the various reform options and philosophies, we hope our findings will stimulate debate and discussion on health insurance expansions among New York State policymakers and stakeholders.

Data and Methods in Brief

For each proposal, we estimate the number of people in New York State eligible for the expansions by categories defined by age, poverty level, and insurance status. We then apply a take-up rate for each program to the aggregate population within each cell. (For example, for a Medicaid expansion, we apply a Medicaid take-up rate to the total number of uninsured adults with incomes below 200% FPL).

There are several differences between our approach and a microsimulation model, such as those used by the Urban Institute and the Lewin Group. In a microsimulation model, program outcomes are modeled based on the projected behavior of individuals. Most microsimulation models also characterize the behavior of firms composed of these individuals. Because behavior is modeled at the individual level, microsimulation models can provide more refined estimates of firm dropping and take-up behavior and individual program responses than we can provide using our cell-based model. Microsimulation models can provide distributions of costs across a wide range of population groups. Our model is only able to distinguish between private and public costs. Finally, our model is calibrated to 2004, while microsimulation models forecast future health care costs. The resulting estimates are intended to provide a framework for discussion of factors that might affect the success of reform in New York State and provoke discussion around model parameters and their applicability in this context.

Introduction

In this report, we provide the results for the second phase of our project consisting of basic modeling of five health reform options for New York State. The reform options selected were based on findings from our earlier analysis¹ as well as input from the New York State Health Foundation's Coverage Consortium. We modeled a single-payer proposal, three variations of "building block" or incremental reforms, including the Community Service Society "Cornerstone for Coverage" plan,² and a plan based on the Manhattan Institute's "Rx NY" proposal.³ Our analysis employs a simple model to provide rough estimates of the likely costs and consequences of these expansion proposals. These basic results are intended to provide a framework for discussion of factors that might affect the success of reform in New York State and provoke further discussion around model parameters and their applicability. Readers should be aware that our findings may differ from the more detailed and precise microsimulation modeling currently being undertaken by the Urban Institute under a contract with New York State.⁴ All of our estimates refer to what spending and coverage would have been in 2004 had these proposals been enacted at that time. They are not intended to be a forecast of future costs. Our simple model does not produce estimates of the distribution of cost across various stakeholders beyond government.

Summary of Proposals

Single Payer

The single-payer or “Medicare-for-All” proposal we modeled was based on a proposal by the Physicians for a National Health Plan Program—New York Metro Chapter.⁵ This reform option would replace all existing insurance in New York—including private insurance, Medicaid, Medicare, etc.—with a single, publicly financed insurance system. In our models we assume that the Federal government would maintain its current effort by providing funding equivalent to Medicare, the federal share of Medicaid, and other federal programs such as those provided by the Department of Veterans Affairs (VA) and federally qualified Community Health Centers. The program would provide a comprehensive benefits package to all residents of New York State, including all hospital inpatient and outpatient services, physician and clinical, dental, emergency room, durable medical equipment, home health care, prescription drugs, and other professional services (i.e. office-based visits to non-physicians). The program would not include nursing home care, non-durable medical equipment, and other personal health care services (such as housekeeping). Under such a program, all premium and cost-sharing expenses, including all co-payments and deductibles, would be eliminated for individuals. The program would be financed entirely through funds currently being spent on government health programs, including Medicaid, and through additional taxes, including the recapture of current employer and individual contributions towards health insurance premiums and out-of-pocket payments.

Building Block 1 and Building Block 2

The first two variations of the “building-block” approach combine a series of incremental health insurance expansion proposals with the option of an individual mandate. The program is designed to increase enrollment in public programs and make individual coverage more affordable for those who do not qualify for government-sponsored insurance. The second version of this approach has higher eligibility benefits and more generous subsidies. Both versions were modeled with and without an individual mandate, which would require all uninsured residents of New York State to purchase some form of health insurance.

Insuring Children First (Expansion of Child Health Plus): This element would increase eligibility for New York State’s Child Health Plus (S-CHIP) program from 250% of the federal poverty level to 400%. It should be noted that while this reform option did not exist in 2004, it is currently being phased-in in New York State.

Expansion of Family Health Plus for Childless Adults: This element would increase eligibility for fully subsidized Family Health Plus for childless adults from its current level of 100% FPL to 150% FPL. We also modeled a second variation, which expands Family Health Plus eligibility for all adults (childless adults and parents) to 200% of the federal poverty level.

Implementation of a Family Health Plus (Medicaid) Buy-In: This measure would allow all adults whose incomes are too high to qualify for the above fully-subsidized Family Health Plus or Medicaid coverage to purchase coverage through Family Health Plus with premium subsidies offered on a sliding scale. In the first version, the premiums would be subsidized on a sliding-scale basis for those between 150% and 300% FPL. Adults whose incomes are above this level

could purchase the coverage at the full premium. In the second variation, the buy-in would apply to adults with incomes between 200% and 400% of the federal poverty level. The premium subsidies are listed in Table 2.

Insurance Connector: An insurance connector in New York State would serve as a new purchasing entity that would allow residents to select between various non-group (individual) coverage plans.

Table II: Summary of Building Block 1 and Building Block 2

	Variation 1	Variation 2
Public Program Expansion	Child Health Plus to 400% of the Federal Poverty Level Family Health Plus for Childless Adults to 150% of the Federal Poverty Level	Child Health Plus to 400% of the Federal Poverty Level Family Health Plus for all adults to 200% of the Federal Poverty Level
Family Health Plus Buy-In	Premium Subsidies for Adults between 150% and 300% of the Federal Poverty Level: 151 – 200% FPL: 80% 201 – 250% FPL: 65% 251 – 275% FPL: 50% 276 – 300% FPL: 25%	Premium Subsidies for Adults between 200% and 400% of the Federal Poverty Level 201 – 250% FPL: 80% 251 – 300% FPL: 60% 301 – 400% FPL: 40%
Insurance Connector	5% decrease in non-group premiums	5% decrease in non-group premiums
Individual Mandate	Option	Option

Building Block 3

The third variation of the building block plan, based on the Cornerstone plan,⁶ proposed by the Community Service Society (CSS) of New York, would provide universal access to health insurance for residents of New York State. It builds on New York’s current public programs – Family Health Plus and Child Health Plus – by expanding eligibility to all income levels. The program would provide comprehensive benefits comparable to those of Family Health Plus/Medicaid for adults and Child Health Plus for children. It would allow children and adults with household incomes below 160% of the federal poverty level to enroll with a full subsidy. Populations at higher income levels, up to 600%, would pay premiums on a sliding scale as a percentage of household income. The program would also allow higher income individuals as well as employers to buy into the program.⁷ The premium distribution used in our analysis for individuals between 160%-600% of FPL was based on the CSS proposal as follows:

Individual Coverage:

- 0 – 160% FPL: 0% (Free)
- 161 – 225% FPL: 1.4%
- 226 – 250% FPL: 1.6%
- 251 – 300% FPL: 2.4%

301 – 350% FPL: 2.8%
351 – 400% FPL: 3.5%
401 – 500% FPL: 4.3%
501 – 600% FPL: 4.7%
>600% FPL: Full Premium

Market-Based Reform

We based our analysis of a market-oriented health reform proposal for New York State on the Manhattan Institute’s Empire Center for New York State’s “Rx NY.”⁸ The elements of the proposal modeled include:

Repeal Community Rating for the Non-Group Market: New York State currently employs pure community rating, which requires that insurers set the same premiums for all individuals, regardless of age and health status. We modeled the age/health status coverage shifts in the non-group market that would result from repealing these laws.

Eliminate Individual State Benefit Mandates: New York State requires that certain health benefits be covered in some form by all health policies regulated by the State. We modeled the coverage effects of eliminating all of New York State’s benefit service mandates for the individual market. The Rx NY proposal recommends eliminating only needless mandates rather than all of them, however our regression results indicate that insurance costs attributed to such mandates have little effect on non-group coverage (see technical appendix). We hence modeled the coverage effects of eliminating all benefit mandates for our analysis.

Establish a High-Risk Pool: We modeled the effects of establishing a high-risk pool in New York State to cover high-cost individuals who would not otherwise obtain insurance. The original proposal specified that funding from the pool would be available through a per-person assessment on anybody with private insurance. However, ERISA prevents any such tax assessment on large employers. We model the coverage shifts that would result from charging the tax for the high-risk pool only to individuals in the non-group and small group market.

Establish Section 125 Cafeteria Plans: A Section 125 Plan, or a cafeteria plan, is a benefit offered by employers that allows employees to purchase health insurance on a pre-tax basis. We modeled the cost and coverage effects of requiring all employers in New York State to offer these plans to their employees.

Short-Term / Temporary Insurance Plans: Several insurance companies offer “short-term medical” plans to individuals who require health coverage for between three months and a year. These plans are available in forty-six states, but are not legal in New York State. We estimated the coverage effects of establishing such plans in New York.

Table III: Summary of Five Options to Increase Health Insurance in New York State

Reform	Eligible Population	Description
Single Payer		
	Entire New York State population.	<ul style="list-style-type: none"> • A publicly financed program that replaces all existing sources of health insurance, including Medicare. • Comprehensive benefit package to all residents, excluding nursing home care, non-durable medical equipment and 'other personal health care' services. • No co-payments or deductibles.
Building Block Variation 1		
Public Program Expansion	<p>All childless adults with household incomes below 150% FPL.</p> <p>All children under the age of 19 in households with incomes below 400% FPL.</p>	<ul style="list-style-type: none"> • Expands eligibility limits of Family Health Plus to 150% FPL. • Expands eligibility of Child Health Plus to 400% FPL.
Family Health Plus Buy-In	Adults with incomes greater than 150% FPL.	<ul style="list-style-type: none"> • Individual adults with incomes greater than 150% FPL could purchase coverage in Family Health Plus. • Premium subsidies would be distributed on a sliding scale basis. • Adults can buy in at full premium if incomes are above 300% FPL.
Insurance Connector	All uninsured individuals and those with non-group insurance would be eligible for premium reduction through non-group market.	<ul style="list-style-type: none"> • Establishes a purchasing mechanism that allows individuals to select from various plans at reduced rates.
Individual Mandate	All remaining uninsured residents of New York State after the public program expansions, buy-in and connector are implemented.	<ul style="list-style-type: none"> • Would require remaining uninsured individuals to purchase available insurance.
Building Block Variation 2		
Public Program Expansion	<p>All adult (childless and parents) residents with household incomes below 200% FPL.</p> <p>All children under the age of 19 in households with incomes below 400% FPL.</p>	<ul style="list-style-type: none"> • Expands eligibility limits of Family Health Plus to 200% FPL. • Expands eligibility limits of Child Health Plus to 400% FPL.

Reform	Eligible Population	Description
Family Health Plus Buy-In	Adult residents with incomes greater than 200% FPL.	<ul style="list-style-type: none"> • Adults with incomes greater than 200% FPL can purchase coverage in Family Health Plus. • Premium subsidies distributed on sliding scale basis. • Adults can buy in at full premium if incomes are above 400% FPL.
Insurance Connector	See Variation #1	<ul style="list-style-type: none"> • See Variation #1
Individual Mandate	See Variation #1	<ul style="list-style-type: none"> • See Variation #1
Building Block Variation 3		
Public Program Expansion	All child and adult residents would be given universal access to the program.	<ul style="list-style-type: none"> • Expands eligibility limits of Family Health Plus and Child Health Plus programs to all income levels to achieve universal access to coverage. • Premiums assigned by household income as a percentage of poverty level.
Employer Buy-In	Full-time workers who have access to public coverage.	<ul style="list-style-type: none"> • Allows employers to buy access to public insurance coverage for their employees. • Employees pay the same share as they would for individual coverage in the program. • Employers pay remainder of the full premium up to 70%. • New York State government pays the remainder, if any.
Market-Based		
Easing Market Regulation	Uninsured individuals and those in the non-group market would be affected by the measure.	<ul style="list-style-type: none"> • Eliminates New York State's community rating laws in the non-group market. • Eliminates New York State's mandated benefits in the non-group market.
Establish a High-Risk Pool	<p>All "medically uninsurable" individuals without access to public or employer-sponsored insurance.</p> <p>Individuals in the small group and non-group market.</p>	<ul style="list-style-type: none"> • Establishes pool for traditionally uninsurable individuals. • The small group and non-group population would be taxed to finance the cost of the pool.
Section 125 Plans	All working individuals (working with ESI, working uninsured with offer of ESI, working uninsured without an offer of ESI).	<ul style="list-style-type: none"> • Allows individuals to purchase health insurance on a pretax basis.
Short Term / Temporary Insurance Plans	Uninsured individuals and those in the non-group market.	<ul style="list-style-type: none"> • Allows people to purchase short term (3-12 months) medical coverage.

Data and Methods in Brief^a

We used a simple cell-based modeling approach. The cells are based on the population in New York State stratified by age, poverty level, and insurance status, obtained from the Census Bureau's Annual Social and Economic Study Supplement of the Current Population Survey (CPS).⁹ In order to increase the precision of our estimates, we pooled CPS data for New York State for 2004-2006. With this increased sample size, we were able to more precisely estimate sub-populations by age and primary insurance coverage and further stratify by additional factors that were necessary for the proposals, including work status, employer size, industry, etc.

We obtained estimates of national per capita health expenditures stratified by age, gender and type of service using the 2004 Medical Expenditure Panel Survey Household Component (MEPS-HC).¹⁰ To obtain New York State health expenditure estimates that conform to the estimates from the Center for Medicare and Medicaid Service's (CMS) National Health Accounts,¹¹ we adjusted the MEPS data using aggregate New York State level expenditure data from CMS. As 2004 is the most recent year that such CMS data is available, our estimates should be interpreted as the effect of each health reform option on New York State costs and coverage had each proposal been in full effect in 2004. Using these baseline data, we then calculated the effects of each proposal on coverage and expenditures for the State by population (age, insurance coverage, poverty level, etc.). In addition, we applied our assumptions and parameters uniformly to each applicable proposal so that most variations in the effects can be attributed to the nature of the proposal. We should also note that our coverage outcome was simply being insured and did not examine the comprehensiveness of coverage. Some reform options, such as single payer, would provide very comprehensive coverage while others, such as the elimination of mandates under the market-based proposal, would reduce the generosity of coverage available.

Key Assumptions

Although many of the parameters that we employ in our analysis have been explored extensively in prior studies, findings from prior studies conflict. As an example, depending on the modeler, price elasticity estimates can vary from -0.1 to -0.6. This means that a 10% reduction in the cost of insurance would lead to between a 1 and 6% increase in coverage.¹² In addition, for some of the proposals, we had to make assumptions for specific elements for which there exists limited data, such as take-up of coverage through short-term/temporary health insurance plans. All of our assumptions are described in our technical appendix. Below we highlight some of the most salient in modeling the five options:

Assumptions for All Proposals

- A 10% reduction in the price of insurance would increase the number of insured by about 3% (varies by income)
- Increases in utilization from covering any proportion of the uninsured can be met by existing provider supply
- Increases in utilization from more generous benefits can be met by existing provider supply

^a A detailed description of all the methods used to arrive at these results, along with a list of all the parameters used and their sources can be found in the technical appendix.

- Any reduction in employer-sponsored insurance (ESI) – through a single payer or crowd-out – will generate a corresponding increase in taxes collected on wages. We assume that average employee contributions will adjust

Assumptions for Single Payer

- Automatic coverage under a zero-premium single payer plan would lead to the enrollment of all uninsured people in New York State
- Any administrative cost savings in the single payer plan would be entirely captured through reduced provider payments
- Uncompensated care cost payments could be withdrawn under single payer coverage

Assumptions for Public Programs

- Increasing eligibility of public programs to higher incomes would increase take-up in uninsured, employer-sponsored insurance and individual (non-group) populations
- Under zero premium voluntary public coverage, no more than 90% of the eligible uninsured would enroll.
- Uncompensated care cost payments could not be withdrawn under incremental reforms
- If 2/3 of a given population group enrolls in coverage voluntarily, a mandate could compel 75% of these remaining uninsured to enroll
- An insurance connector could reduce administrative costs by 5%
- Providers would take any number of additional FHP and CHP enrollees at prevailing payment rates
- For low income uninsured people not eligible for public programs, the primary barrier to health insurance is cost. For higher income uninsured people, in addition to cost, other unmodeled factors (such as expected duration of joblessness) also matter.
- Most people who now purchase non-group coverage would switch to a public plan if it were less expensive and comprehensive, but 20% would stick with private coverage
- People who already hold ESI would only be about 1/3 as likely as similar uninsured people to voluntarily switch to a new insurance product
- Employers of higher wage workers would be less responsive to the availability of expanded public insurance programs than would employers of lower wage workers
- Only small firms with fewer than 10 employees would drop coverage if new public coverage were available (unless an employer buy-in were implemented), though some employees would switch to public coverage
- In plans with an individual buy-in, individuals compare their current share of the insurance premium to the new public premium; in plans containing an employer buy-in, the full ESI premium is compared to the combined employee and employer payments under the public program.

Assumptions for Market-Based Proposals

- 75% of firms that do not now do so would comply with a mandate to offer Section 125 cafeteria plans
- The elimination of community rating and the substitution of community rating with high-risk pools are two different strategies that could not happen simultaneously

Results

Our baseline scenario was that in 2004 there were 19.0 million people living in New York State of whom 16.4 million were insured and 2.6 million were uninsured. Of the insured, 11.0 million were covered by employer-sponsored insurance, 0.1 million by individual, non-group coverage and 5.3 million by public coverage (Medicare, Medicaid and/or SCHIP). Total health expenditures for New York State in 2004 were \$134 billion (includes all services and insurer administration). Total health expenditures excluding nursing home care, non-durable medical equipment, and other personal health care expenditures came to be \$113 billion. Under these baseline assumptions, had the following alternative coverage proposals been in effect in 2004, the changes to our baseline assumptions would be as follows:

**Table IV:
Estimated Cost and Coverage Impacts for All Five Options***

Total Covered Through Plan ^a (Thousands)	Reduction in Number Uninsured (Thousands)	Crowd-Out of Private Insurance (Thousands)	Remaining Uninsured (Thousands)	Net Additional State Gov't Cost ^c (Millions)	Net Increase in Health Spending ^d (Millions)
Single Payer					
19,000 ^b	2,600	11,300	0	\$66,800	\$5,800
Building Block Variation 1					
Without Mandate					
800	500	300	2,100	\$1,000	\$900
With Mandate					
2,400	2,100	300	500	\$4,000	\$5,000
Building Block Variation 2					
Without Mandate					
1,100	700	400	1,900	\$1,900	\$1,000
With Mandate					
2,700	2,300	400	300	\$5,200	\$5,200
Building Block Variation 3					
1,500	1,000	500	1,600	\$3,600	\$1,600
Market-Oriented					
100-130	100-130	0	2,500	\$130	\$280-\$440

* Estimates may not sum due to rounding.

^aTotal covered through plan represents all the individuals who will enroll in some form of insurance as a result of enacting this plan. This includes the uninsured who become newly insured as well as individuals already covered by private insurance (employer or individual) and would now switch to this new coverage (crowd out).

^bThe single payer system replaces all existing insurance programs. Therefore, all people with private insurance would be covered under single payer. In addition, columns 2 and 3 do not sum to column 1 because the "total covered through plan" also includes all people previously on public insurance (Medicare, Medicaid, etc.) now part of the single plan.

^cThe net additional government cost represents the additional amount of money the New York State government will have to contribute in order to finance the plan.

^dThe net increase in health spending represents the change in overall health spending that will result from the enactment of the plan. It is calculated as the sum of all health expenditures (government, private, and out-of-pocket and administration) after the plan is enacted minus current level of health expenditures.

Single Payer Plan

A single payer program would automatically cover all New Yorkers and no resident of the State would be excluded from coverage. It would provide comprehensive benefits and eliminate all cost sharing for all New Yorkers, including the elimination of cost sharing for those previously insured through public or private coverage. Excluded from coverage would be nursing home care, non-durable medical equipment, and ‘other personal health care’. Excluding these costs, we estimate baseline total health expenditures in New York State of \$113 billion. Under this program, New York State would see an increase in utilization of health care services by the previously uninsured population, which we estimate at approximately \$7.8 billion. Given the elimination of cost-sharing, we also predict a substantial increase in utilization among both the privately insured and among the Medicare population that currently do not hold supplemental insurance. These increases would be about \$9.8 billion for those now privately insured and \$1.6 billion for Medicare beneficiaries.

Offsetting this \$19.2 billion increase in health expenditures would be reductions in administrative costs and uncompensated care costs. We estimate a reduction in insurance administrative costs of \$3.6 billion. The provider administrative savings would amount to \$4.3 billion for hospitals and \$2.5 billion for physicians. Total administrative savings under the single payer system would be approximately \$10.4 billion. We estimated total uncompensated care cost savings in New York State to be approximately \$3.0 billion. With these total savings of \$13.4 billion, overall, there would be a net increase in health spending in New York State of about \$5.8 billion.

The outlays for the State government under this program would be \$118.8 billion for health care costs and program administration. Offsetting these costs would be payments under maintenance of federal effort for New York State health expenditures, which would be transferred to New York State once the program is established. We assume that people who previously held employer-sponsored coverage would receive higher wages in lieu of these benefits. These wages would be subject to a state tax on wages equivalent to the average state marginal tax rate on the average employer share of the New York State insurance premium. This would offset the total cost of the single payer program by approximately \$1.7 billion. Combining these offsets, the net increase in expenditures for the New York State government for the single-payer program would be approximately \$66.8 billion. These new outlays would need to be financed through new taxes on employers and individuals. Note, however, that employers would no longer need to provide insurance for employees under single payer and individual out-of-pocket costs would be substantially reduced as there would no longer be any co-payments or deductibles for services covered under the single payer. These employer and individual savings amount to approximately \$61 billion. Thus, the increase in New York State spending of \$66.8 billion could be offset, in large part, by recapturing individual and employer savings.

Table V: Change in New York State Health Spending Under a Single Payer Plan*

	Change in Health Spending (Millions)
Baseline Health Spending (without nursing home care, non-durable medical equipment, and 'other personal health care')	\$113,000
Increase in Utilization	
Uninsured	7,800
Privately Insured	9,800
Medicare w/out Supplemental Insurance	1,600
Spending Offsets	
Insurer Administration	(3,600)
Hospital Administration	(4,300)
Physician Administration	(2,500)
Uncompensated Care Reduction	(3,000)
Change in Statewide Health Spending	
Net Change	5,800

* Estimates may not sum due to rounding.

Table VI: Additional Government Costs of a Single-Payer Plan in New York State*

	Cost (Millions)
Payments for Personal Health Care	\$122,500
Program Administration	6,100
Reduction in Provider Administrative Costs and Uncompensated Care	(9,900)
Total Costs	118,800
Current Government Expenditures (Transfers)	
Medicare	(22,700)
Medicaid	(24,200)
Federal	(12,800)
State	(11,400)
Other Government Expenditures (Veterans Administration, Other Federal Sources, Other State and Local Sources, Worker's Compensation, Other Public)	(3,300)
Federal	(2,800)
State	(500)
Taxes from Increased Wages	(1,700)
Net Government Costs	
Total	66,800
Note: A substantial portion of the net government cost would be offset by the recapture of employer and individual spending, totaling approximately \$61 billion.	

* Estimates may not sum due to rounding.

Building Block Plans

Variation 1: The building block proposals would increase insurance options for those currently uninsured and would cause some of those currently insured through private coverage to switch coverage to public programs (known as crowd-out).

We estimate that the plan component of expanding the Child Health Plus program for all children below 400% of the federal poverty level would insure an additional 50,000 previously uninsured children (as noted above New York State has recently implemented this SCHIP expansion). An additional 200,000 children who previously had coverage through their parents' employer and another 7,000 who previously had non-group coverage would transfer into the program. The net government cost for these new enrollees would be \$300 million.

Expanding Family Health Plus for childless adults below 150% of the federal poverty level would cover 80,000 uninsured adults. We estimate the crowd-out for this expansion would be approximately 20,000 who previously had employer-sponsored insurance (ESI) and 6,000 who previously had non-group coverage. The net government cost would be \$400 million.

We estimate that implementing a Family Health Plus Buy-In that offers premium subsidies for adults between 150 and 300% of the federal poverty level would reduce the uninsured by 400,000 and another 50,000 with non-group coverage and 20,000 with ESI would switch into the program. The total government cost under the buy-in for covering these 500,000 enrollees would be \$400 million.

Implementation of an insurance connector would reduce premiums in the non-group market and increase coverage by approximately 1,000 individuals.

Overall under these expansions an additional 500,000 persons would gain coverage and another 300,000 would switch from private to public coverage at a total New York State government cost of \$1 billion. If this variation also included an individual mandate, an additional 1.6 million uninsured would take up coverage with whichever insurance source was available to them at the lowest price. This would increase government costs by \$3.0 billion. The New York State government would realize some savings from increased taxes on wages for those who had employer-sponsored coverage and switched to one of the public programs, totaling approximately \$40 million. Overall, Variation 1 combined with an individual mandate would newly cover 2.1 million people and 300,000 would switch from private to public coverage at a New York State government cost of \$4.0 billion.

To estimate the net change in overall health care expenditures under this variation of the "building block" plan we subtracted the affected populations' health expenditures under the current system from the total spending that people who take up coverage would have under this plan. As shown in Table IX, we found that under this variation, New York State would see a net increase in total health spending of \$5.0 billion generated primarily by new health spending for the previously uninsured who take up coverage under the mandate.

Variation 2: Under a slightly more generous Building Block proposal, we estimate that without an individual mandate, 700,000 uninsured would gain coverage and 400,000 would switch from private to public coverage. The government cost for these 1.1 million people would be approximately \$1.9 billion. If combined with an individual mandate, overall 2.3 million

uninsured would gain coverage and 400,000 would switch from private to public coverage at a government cost of \$5.2 billion. The New York State government would see small savings in the form of increased wage taxes on individuals who switched from private to public coverage, totaling approximately \$50 million. Under this variation, total healthcare spending in New York State would increase by \$5.2 billion.

**Table VII: Costs and Coverage under the Building Block Plans
Variation 1***

	Total Covered Through Plan	Reduction in Uninsured	Previously with ESI	Previously with Non-Group	Government Costs for New Enrollees (Millions)
Child Health Plus Expansion (Children <19 to 400% FPL)					
Insured	300,000	50,000	200,000	7,000	\$300
Family Health Plus Expansion (Childless Adults >18 to 150% FPL)					
Insured	100,000	80,000	20,000	6,000	400
Family Health Plus Buy-In					
Insured	500,000	400,000	20,000	50,000	400
Insurance Connector					
Insured	1,000	1,000	0	0	0
With Individual Mandate					
Insured	1,600,000	1,600,000	0	0	3,000
Taxes from Increased Wages					(40)
Total					
Insured	2,400,000	2,100,000	200,000	70,000	4,000

* Estimates may not sum due to rounding.

**Table VIII: Costs and Coverage under the Building Block Plans
Variation 2***

	Total Covered Through Plan	Reduction in Uninsured	Previously with ESI	Previously with Non-Group	Government Costs for New Enrollees (Millions)
Child Health Plus Expansion (Children <19 to 400% FPL)					
Insured	300,000	50,000	200,000	7,000	\$300
Family Health Plus Expansion (All Adults >18 to 200% FPL)					
Insured	300,000	200,000	100,000	10,000	1,200
Family Health Plus Buy-In					
Insured	500,000	400,000	30,000	40,000	500
Insurance Connector					
Insured	1,000	1,000	0	0	
With Individual Mandate					
Insured	1,600,000	1,600,000	0	0	3,400
Taxes from Increased Wages					(50)
Total					
Insured	2,700,000	2,300,000	300,000	70,000	5,200

* Estimates may not sum due to rounding.

**Table IX: Change in Health Spending Under the Building Block Plans
Variations 1 and 2***

	Change in Health Spending (Millions)
Variation 1	
Child Health Plus	\$(200) ^a
Family Health Plus	200
Family Health Plus Buy-In	1,000
Insurance Connector	3
Mandate	4,000
Net Change in Health Spending	5,000
Variation 2	
Child Health Plus	\$(200) ^a
Family Health Plus	400
Family Health Plus Buy-In	900
Insurance Connector	3
Mandate	4,100
Net Change in Health Spending	5,200

* Estimates may not sum due to rounding.

^a Expansion of Child Health Plus to 400% FPL would generate a net decrease in spending due to a large population of children switching from private to public coverage with its reduced average spending.

Variation 3: The third variation of the Building Block proposals would expand coverage by increasing enrollment eligibility for public coverage to all income levels. The relatively higher income eligibility levels and the employer buy-in element would also lead to greater take up among the privately insured. We estimate that the plan would reduce the number uninsured by 1.0 million. In addition, approximately 100,000 individuals who previously had non-group coverage and 400,000 who previously had employer coverage would switch to public coverage. The total costs to New York State to cover these 1.5 million persons would be \$3.6 billion. Under this plan, total health spending would increase by much less—only approximately \$1.6 billion—because crowd-out would lead people to drop private coverage in favor of less costly coverage under the public plan^b.

**Table X:
Cost and Coverage under the Building Block Plans
Variation 3***

Income Range	Total Covered Through Plan	Reduction in Uninsured	Previously Non-Group	Previously ESI	Total New York State Costs (Millions)
Building Block 3 Expansion					
0 to 160%	600,000	300,000	40,000	200,000	1,800
161 to 225	400,000	200,000	20,000	100,000	1,000
226 to 250	90,000	50,000	5,000	30,000	200
251 to 300	100,000	90,000	10,000	10,000	300
301 to 350	80,000	80,000	5,000	0	200
351 to 400	60,000	60,000	5,000	0	100
401 to 500	70,000	60,000	8,000	0	90
501 to 600	50,000	40,000	6,000	0	30
>600	100,000	90,000	10,000	0	0
Taxes from Increased Wages					70
Total	1,500,000	1,000,000	100,000	400,000	3,600

* Estimates may not sum due to rounding.

**Table XI: Change in Health Spending under the Building Block Plans
Variation 3**

	Change in Health Spending (Millions)
Net Change in Spending	1,600

^b We assume that there are no limits on the supply of providers under the public plan.

Market-Based Plan

The market-based plan includes several components: two options for deregulating insurance markets, enabling new products to be sold, and making better use of existing tax subsidies.

The proposal includes two options for reducing the impact of community rating in the New York State market. Option one, repealing community rating laws in the New York State non-group market, would result in a coverage shift among the uninsured of various health statuses. Persons who are relatively healthy would see an increase in coverage, while coverage would decline among older, sicker people. Overall we estimate that a net of approximately 60,000 people—primarily those who reported “excellent” or “very good” health status—would gain coverage due to lower costs associated with repeal of community rating.

Alternately, New York State could establish a high-risk pool at a premium of 150% of the non-group premium (assuming no community rating, the average premium would be \$4,500 per person). This high-risk pool would insure approximately 9,000 currently uninsured people. In addition, we estimate that 40,000 individuals currently enrolled in the non-group market would take up coverage in this high-risk pool. In conjunction with the establishment of the high-risk pool, low risk purchasers could buy experience rated coverage. We estimate that this will insure an additional 20,000 lower risk uninsured in non-group coverage. The cost to New York State for covering persons in this high-risk pool would be \$160 million (\$2,900 per individual in the pool). In the Manhattan Institute proposal, the pool would be funded by a tax on individuals with private insurance coverage. We modeled the coverage effects of the tax on the non-group and small-group market only (because of ERISA)^c. We estimate each member of this population would have to pay an additional \$90 annually in order to offset the additional costs needed to provide coverage for the uninsured who would take up coverage under these high-risk pools. We estimate this additional cost would reduce coverage in the non-group and small-group markets by approximately 10,000. Thus, the net effect of the high-risk pool on overall coverage in New York State would be approximately 20,000. Unlike the option of repealing community rating altogether, this option would not have the effect of skewing the mix of non-group insured populations toward healthier people.

Eliminating New York State’s benefit mandates in the individual market would result in an increase in non-group coverage of approximately 30,000. This estimate represents the increase in coverage by eliminating all benefit service mandates strictly in the individual market. The original “Rx NY” proposal specified eliminating only needless mandates, yet as we did not have a way of identifying these, we estimated the effect of eliminating all service mandates.

A requirement for employers to offer Section 125 Flexible Benefit Plans or cafeteria plans to employees would affect approximately 700,000 of those currently uninsured. These plans allow employees to use their own pre-tax dollars to buy coverage with no employer contribution. We estimate that 30,000 of the uninsured would take-up coverage if offered Section 125 plans, at a government cost of approximately \$710 million due to lost tax revenues. Of this lost revenue, \$580 million would be borne by the federal government and \$130 million by New York State.

^c The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. Under this law, states may not regulate self insured health plans. Such regulation includes the taxation of large groups. (United States Department of Labor).

This cost includes the lost revenue from the approximately 3 million full-time working individuals who already hold employer coverage and do not have access to Section 125 plans who would take advantage of the favored tax benefits of the program once available.

Finally, we estimate that allowing New York State to offer temporary insurance plans would insure an additional 20,000 persons. As there is very little data available on take-up in such plans, we used similar take up rates as those observed in Florida’s short-term medical plans (see technical appendix).

Overall, the market-based plan would result in approximately 100,000-130,000 uninsured persons gaining coverage at a cost to New York State of \$130 million. In Table XIII, we detail the total health expenditures associated with each component of the market-based proposal, along with the offset generated primarily by current spending among the uninsured who take up coverage through the plan. It should be noted the costs of the newly insured individuals through the high-risk pool and the individuals already with employer-sponsored insurance (ESI) who take up Section 125 plans would not affect the change in net health spending under the proposal since the medical costs for those individuals would remain unchanged, but be financed by different stakeholders. However, the reduction in spending that would arise from individuals in the small group and non-group markets dropping coverage as a result of the tax from the high-risk pool are included in this offset. Using this methodology we found that overall health spending in New York State would increase by \$280 - \$440 million.

**Table XII:
Cost and Coverage under the Market-Based Plan***

Measure	Newly Insured	Total New York State Costs (Millions)
Repeal Community Rating	60,000	\$0
High-Risk Pool		0
Newly Insured in Pool	9,000	
Newly Insured in Non-Group Market	20,000	
Insurance Drop (Due to Tax on Privately Insured)	(10,000)	
Eliminate Benefit Mandates	30,000	0
Section 125		710
Newly Insured	30,000	580 (Fed) 130 (State)
Short-Term/Temporary Insurance	20,000	0
Total	100,000 – 130,000^a	\$130 (State)

* Estimates may not sum due to rounding.

^a We provide a range of estimates, as we assume that the repealing community rating and high-risk pool components cannot be implemented simultaneously.

Table XIII: Change in Health Spending Under the Market-Based Plan*

	Change in Health Spending (Millions)
Repeal Community Rating	\$200
High-Risk Pool	30
Eliminate Benefit Mandates	100
Section 125 Plans	90
Short Term / Temporary Insurance	50
Net Change in Health Spending	\$280 – \$440^a

* Estimates may not sum due to rounding.

^a We provide a range of estimates, as we assume that the repealing community rating and high-risk pool components cannot be implemented simultaneously.

Table XIV: Cost Impact of All Five Options for New York State*

Total Insured in New York State (Thousands)	Newly Insured (Thousands)	Additional Government Cost Per Newly Insured	Net Cost Per Newly Insured^a
Single Payer			
19,000	2,600	\$25,900 ^b	\$2,200
Building Block Variation 1			
Without Mandate			
17,000	500	\$1,900	\$1,700
With Mandate			
18,600	2,100	\$1,800	\$2,300
Building Block Variation 2			
Without Mandate			
17,100	700	\$2,900	\$1,600
With Mandate			
18,700	2,300	\$2,300	\$2,300
Building Block Variation 3			
17,400	1,000	\$3,600	\$1,600
Market-Oriented			
16,500 – 16,600	100 - 130	\$1,000 - \$1,400	\$2,900 - \$3,200

* Totals may not sum due to rounding.

^a Derived as the net change in health spending due to implementation of the proposal divided by the newly insured (reduction in uninsured).

^b A substantial portion of this cost would be offset by the recapture of employer and individual spending.

Discussion

In this report, we have provided estimates of coverage and costs for five policy options aimed at expanding health coverage in New York State. Our choice of policy options was based on our review of testimony at various public hearings as well as input by members of the NYSHHealth Coverage Consortium. Thus, the options modeled here likely represent a realistic cross-section of some of the most popular approaches to reform in New York State ranging from those that rely solely on government coverage to those that are primarily market based. We have applied the same cost and coverage estimates to each proposal and shared similar assumptions whenever feasible.

The single payer approach would cover all New Yorkers through a State-administered comprehensive plan. This approach attains the greatest level of coverage; it covers all of the 2.6 million uninsured residents of the State. It provides the most comprehensive benefits package, offering an improvement in the generosity of benefits to virtually all New Yorkers, including those who now hold private insurance or Medicare. However, the plan shifts all the cost of covering both the newly insured and the previously privately insured entirely to the New York State government so that from a governmental perspective, the single payer approach would have the greatest public costs. New York State would have to raise an additional \$66.8 billion to finance the plan. Almost all of this of this net cost, however, would be offset by reductions in spending by employers and individuals. Moreover, this plan would realize the greatest savings in administrative expenses and uncompensated care costs. While net health spending would rise because of an increase in utilization, a much higher fraction of costs would go to paying for health services rather than insurer or provider administrative expense.

The market-based approach would expand coverage by making private health insurance markets more affordable. This approach would insure between 100,000 and 130,000 of New York State's uninsured population, the lowest gain among approaches modeled. For many New Yorkers, coverage levels under this approach would be less generous than current levels and would include significant cost-sharing. This option would impose the least cost burden to the New York State government, requiring only about \$130 million in new government outlays per year. From a New York State perspective, this cost would be the lowest among approaches modeled.

The three building block or incremental approaches we modeled consist of multiple incremental strategies to expand coverage. Those building block models that do not include a mandate result in modest reductions in the uninsured, newly covering one million or fewer. From a New York State government perspective, the costs are also modest, particularly for the first two options we modeled. Without a mandate, option one (the least generous of the three in terms of government expansion and subsidies) covers nearly 500,000 people at a public cost of \$1.0 billion. The most generous approach would cover twice as many, even without a mandate, but would also be more costly. Adding a mandate to a building block approach could achieve nearly universal coverage, leaving fewer than half a million New Yorkers without insurance. These options would be much more costly however.

The results here provide a general overview of the coverage effects and cost implications for New York State associated with popular expansion proposals. We made no attempt to assess the

distributional implications of the proposals or to project costs forward. Our results suggest that any insurance expansion will involve tradeoffs between numbers covered and costs. No single approach clearly dominates the others.

The results are derived from a model based on national assumptions. Our findings are intended to stimulate debate and discussion among policymakers and stakeholders who should use our results as a reference of the broad implications and tradeoffs among the various options and philosophies of expanding health insurance in New York State. To this end, we provide a detailed description of all the methods used to arrive at these results, along with a list of all the parameters used and their sources in the technical appendix. By providing such an open and transparent model, we expect that a healthy debate of our assumptions and parameters will ensue. This input will be critical in the next phases of our work where we will examine additional New York-specific considerations that need to be considered in future modeling. We hope the process will also lead to furthering the engagement of New York State policymakers in the health reform process.

We would encourage readers of our report to send us any comments. Comments should be sent to Nicholas Tilipman at nt2232@columbia.edu.

Technical Appendix: Estimating Assumptions and Methods

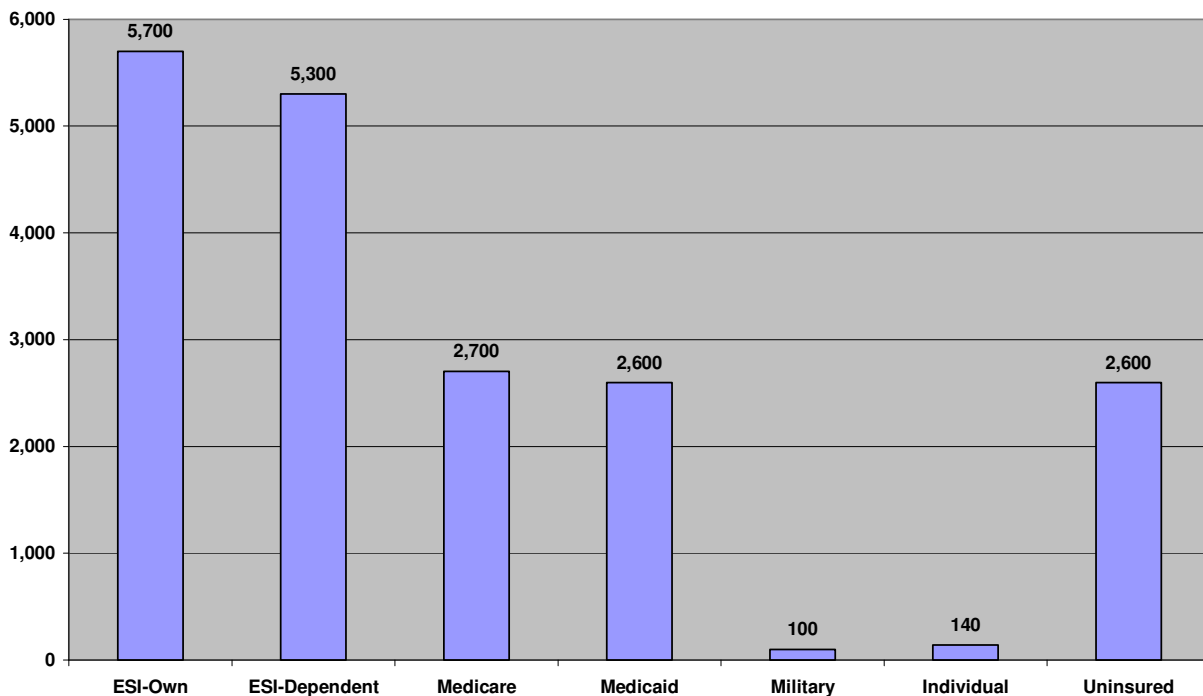
Table XV lists all of the assumptions, parameters and sources that were used in the modeling analysis.

Baseline Estimates and Uniform Assumptions

Population Estimates: We estimated coverage in New York State by age and poverty level using State-level data from the March supplement (Annual Social and Economic Study) of the Current Population Survey (CPS). We combined CPS data for New York State for 2004, 2005, and 2006 to increase sample size and allow us to estimate the set of sub-populations by age, primary insurance coverage, etc. We assigned people to health insurance units (HIUs) and assigned each individual to a source of primary insurance coverage (Medicare, Medicaid, Private Insurance, Uninsured), which we based on an insurance hierarchy. For example, an individual who was enrolled in both Medicare and either Medicaid or private insurance during the year was placed into the ‘Medicare’ category. We did not adjust our Medicaid population estimates for the underreporting of Medicaid in CPS.¹³

Figure 1

Baseline Coverage In NYS 2004 (In Thousands)



Source: Annual March Social and Economic Study Supplement Current Population Survey, 2004-2006.

Non-Group Population Adjustments: The CPS grossly overstates New York State’s actual non-group population. Therefore we adjusted our estimates of current enrollment in individual coverage using estimates for 2006 that we obtained from the New York State Insurance

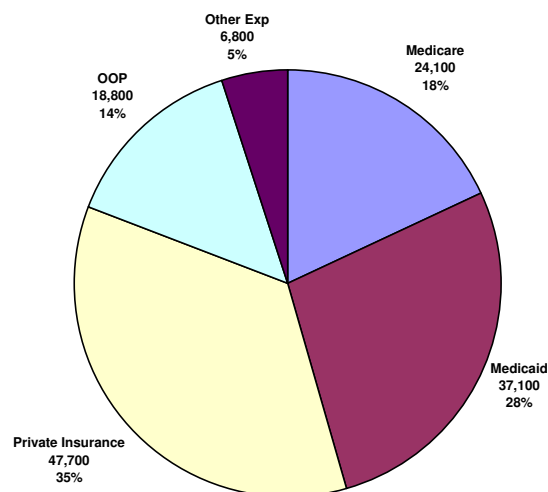
Department.^d The adjustments reduced the CPS non-group estimate by about 600,000. We reassigned those excluded from non-group coverage to employer-sponsored insurance and Medicaid according to household income.

State Health Expenditure Estimates: We obtained estimates of national per capita health expenditures in 2004 using the Medical Expenditure Panel Survey (MEPS)'s Household Component and stratified spending by different population cells—age, gender, type of service, primary insurance coverage, and source of payment. We adjusted the MEPS data by State-level health expenditure estimates from the 2004 Centers for Medicare and Medicaid Services (CMS) National Health Accounts (the last year of cost data available at the State level). This allowed us to obtain State-level expenditure estimates for New York. Using these two datasets, we created adjustment factors for per-capita expenditures by type of service for Medicare payments and Medicaid payments. We derived an adjustment factor for per capita non-Medicare, non-Medicaid payments as well by subtracting these payments from each dataset and dividing by the total population. We used this adjustment factor to inflate all private insurance expenditures, out-of-pocket expenditures, and other payments.

As the CMS includes all types of health care services and supplies in the data (nursing home care, expenditures for non-durable medical products – i.e. over-the-counter, non-prescription medication, etc. – or other personal health care, such as housekeeping services, industrial in-plant expenditures, etc.), we excluded these categories from our estimates by creating adjustment factors between the MEPS estimates and CMS estimates with those categories removed. These data form our baseline for current health care spending in New York State.

Figure II

**Health Spending in New York State in 2004 by Source of Payment
All Services (In Millions)**

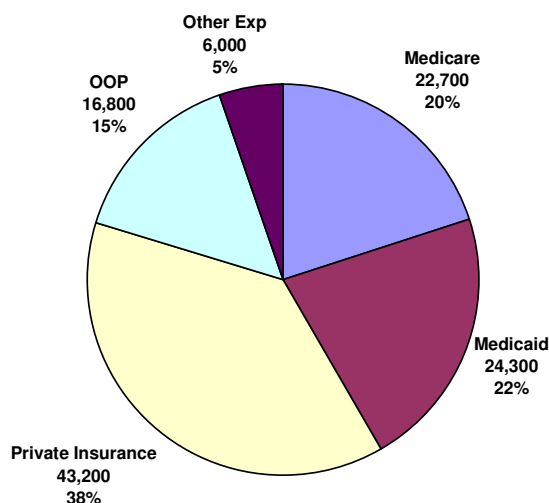


^d In 2006, there were approximately 62,000 people in New York State's standardized direct pay market, and an additional 79,000 who held insurance through other non-group products.

Source: Medical Expenditures Panel Survey, Household Component, 2004.

Figure III

**Health Spending in New York State in 2004 by Source of Payment
Without Nursing Home, Non-Durable Products, Other Personal Health Care
(In Millions)**



Source: Medical Expenditures Panel Survey, Household Component, 2004.

Administrative Cost Estimates: We calculated an administrative component for the Medicare program, Medicaid program, and private health insurance based on CMS estimates for national administrative/overhead expenses as a percentage of benefit payments for personal health care. In 2004, Medicare’s administrative costs were 3.5% of the program’s total payments for personal health care and Medicaid’s administrative costs were 7.5%. We used national net costs of private health insurance (average premiums less benefit payments) as the administrative component of private insurance. This amounted to approximately 15% of payments for personal health care services. We assume that administrative costs for these insurance plans are similar in New York State¹⁴

Individual Premiums for New York State’s Public Programs, Employer-Sponsored Insurance, and Non-Group Coverage: For people enrolling in Family Health Plus, we used cost and coverage data for 2004 from the New York State Department of Health. We used the Medicaid Prepaid Services Expenditure Reports and the Average Monthly Medicaid Beneficiaries reports in order to estimate the average annual expenditures per beneficiary for the Family Health Plus program. This came to \$3,545¹⁵

For children enrolling in Child Health Plus, we used cost and coverage data from the Kaiser Family Foundation’s “StateHealthFacts.org.” We used information on historical SCHIP spending for 2004 and the SCHIP monthly enrollment estimates in order to estimate total expenditures per enrollee for the year. This came to \$1,040¹⁶

For enrollees in Building Block 3, we used a weighted average of the FHP and CHP premium based on the number of uninsured children and adults eligible for the program. This came to \$3,190.

In addition to public costs, we needed to estimate premiums in the private market in order to calculate the price change for those with access to employer-sponsored insurance (ESI) or non-group coverage under buy-in and the insurance connector. We estimated the average employee share of the ESI premium using data from the MEPS 2004 Insurance Component. This came to approximately 20% of the full premium.¹⁷ For non-group prices, we assumed that individuals without an ESI offer whose household incomes were below 250% of the federal poverty level were eligible for coverage in the Healthy New York program. For this population, we used the average monthly premium for Healthy NY from the *Annual Report on the Healthy New York Program* put out by the New York State Insurance Department (\$1,908).¹⁸ For those with incomes above 250% FPL, we assigned a non-group premium based on the average HMO premiums for non-group coverage according to the New York State Insurance Department Premium Rates Index.¹⁹ As this figure was only available for the current year (2008), we deflated the average premium to 2004 dollars using CMS average growth rates. We created a conversion factor between average growth rates in the United States and average rates in New York State between 2000 and 2004. We applied this factor to projected national growth rates through the year 2008. The full employer premium came to \$3,391 and the individual, non-group premium came to \$8,178.

These non-group figures are actual figures for New York State, assuming that its current community rating laws are in place. For those proposals in which we assume no community rating (i.e. the high-risk pool in the “Rx NY” proposal), we apply Connecticut’s non-group premium (\$3000), taken from American Health Insurance Plans.²⁰ We do this since Connecticut’s market is relatively de-regulated and its average health costs are similar to New York State.

Price Elasticity and Take-Up Rates: Many studies have looked at how the number insured would respond to changes in price of health insurance (price elasticity), yet an overall consensus has not been reached. For example, the Lewin Group’s analysis of a Family Health Plus Buy-In for New York State employed price elasticity estimates that ranged from -0.55 percent to -0.09 percent, depending on an individual’s socio-economic characteristics (i.e. a one percent reduction in premiums would increase take up by 55 percent among those of lowest income levels, and of 9 percent among the highest income levels).²¹ The Employment Policies Institute, in its study of the Bush tax credits in 2007, used a lower average estimate of -0.1 for the price elasticity for demand of health insurance.²² We used price elasticity estimates of -0.3 for those individuals whose household incomes fell below 200% of the federal poverty level and -0.15 for those whose incomes were above 200% in order to estimate take-up of health insurance (specifically through the availability of a Family Health Plus Buy-In and take-up of non-group coverage due to price reductions).

In order to estimate take-up by the uninsured, we converted these price elasticity estimates by multiplying them by the ratio of percentage of the privately insured potentially eligible to the percentage of the uninsured eligible for the given insurance. This yielded a take-up elasticity for the uninsured that we applied to estimate new enrollment into the FHP buy-in, etc. by poverty level, using the estimated price changes. Since there are fewer uninsured and more privately insured (especially through employer-sponsored insurance) at higher income levels than at lower

levels, our take-up elasticity estimates for those populations are high (these estimates along with substantial price reductions for health insurance would imply a 100% take-up rate among the uninsured at higher income levels). We cap our take-up rates at 90%, assuming that some uninsured would remain uninsured despite the availability of cheaper coverage.

Crowd-Out: We assume that increases in eligibility of public programs to higher incomes would lead to an increased take-up among the privately insured. This is known as crowd-out. To measure crowd-out under each of the public program expansions as well as under public program buy-ins, we assumed that take-up elasticity among the population with employer-sponsored insurance was approximately 30% as high as it was for the uninsured.²³ We assumed that take-up among the non-group coverage population was 80%. Using these figures, we calculated crowd-out rates by poverty level to represent the percentage of previously privately insured that would take up public coverage under the proposal.

We assume that any reduction in employer-sponsored coverage through crowd-out would generate a corresponding increase wages and, hence, in taxes collected on wages.

Single Payer Adjustments

Coverage through the Single Payer Program: We assume that all residents of New York State would automatically be covered under the zero-premium, comprehensive single payer program.

Reduction in Cost-Sharing: Under the single-payer proposal, cost-sharing would be completely eliminated. We estimate that this would lead to an increase in utilization of health services among those who pay significant out-of-pocket costs under the current system (most who have private insurance as their primary coverage). In order to adjust for increased healthcare utilization due to a reduction in cost-sharing from an average of 25% to 0%, we inflate total spending for the privately insured population by 20.7% for children and 23.8% for adults, using the RAND estimates.²⁴ These RAND estimates are slightly higher than those used by Lewin in the Lewin group's analysis of a single payer program in California.²⁵

Utilization of the Uninsured: We assume that per capita expenditures for the uninsured would rise to the same level of expenditures as the formerly privately insured population for each age group. A recent study by the Urban Institute estimated that fully covering all the uninsured in the United States would increase their spending by \$122 billion, or 5.1% of national health expenditures.²⁶ Our estimate of \$7.8 billion is slightly higher (approximately 7.6% of national health expenditures, excluding administration). This is due primarily to the increased generosity of the benefits in our model. Other estimates model utilization by extending current private coverage to the uninsured, which includes co-payments and deductibles. In our model, the coverage that the previously uninsured would receive would not have any cost-sharing.^e

Utilization of the Medicare Population without supplemental insurance: We estimate that 12% of the current Medicare population does not have supplemental private insurance, and faces full

^e Had we calculated the change in spending for the uninsured by assigning them average per capita expenditures of current privately insured individuals (with cost-sharing), then our estimate for the increase in spending for the uninsured would be 5.1% of our baseline for national health expenditures – very similar to Urban Institute's latest estimates.

Medicare cost-sharing.²⁷ We inflated the health care costs of this population, assuming that a single-payer plan would be the equivalent to providing comprehensive supplemental insurance to the entire Medicare population. We assumed that supplemental insurance increases Medicare expenditures by 6.7%²⁸. We also assumed the cost of the supplemental insurance would be equal to the average private insurance payments for the Medicare population also holding private insurance for all services (with the exception of those not covered by the single-payer). We inflated the total costs to the Medicare population without supplemental insurance by assigning them the same expenditures as the full-year Medicare, privately insured population (approximately \$4,300 per enrollee). We assume that Federal maintenance of effort would only reflect current Medicare payments.

Reduction in Insurer and Provider Administrative Costs and Uncompensated Care: A single-payer system would reduce insurance administrative expenses, as multiple and competing plans would be consolidated into one publicly financed and publicly administered mechanism. In addition, the overhead expenses faced by providers—hospitals and physicians—would be diminished, as the costs associated with billing, budgets, and filing claims would be simplified.

Insurance Administrative Costs: Current studies vary in their assumptions about the effect of a state single payer plan on insurer administration. Many analysts modeling single payer use Medicare's administrative costs. For example, the Lewin Group, in its analysis of implementing a single-payer plan in California, reduced administrative costs from 7.6% to 2.3%²⁹ Ken Thorpe, in his analysis of Vermont, assumed an administrative cost rate of 3% of total insurance claims.³⁰ In this analysis, we assume a somewhat higher administrative cost rate under a single-payer system, 5%—one that falls between the Medicare program and the Medicaid program—primarily because the challenges and costs of enrolling the non-elderly population would be higher than for Medicare, which primarily enrolls the social security eligible population. Our estimate is similar to that used by Mathematica Policy Research in their analysis of the feasibility of a single-payer system in Maine.³¹

Provider Administrative Costs: There is little consensus in existing literature on the appropriate reduction in provider administrative costs under a single payer plan. In 1992, the Lewin Group estimated a reduction of approximately 14% for hospitals and approximately 26% for physicians.³² These estimates were based on an analysis of physician administrative expenses as reported by the Medical Group Management Association (MGMA) surveys and an analysis of administrative expenses faced by California hospitals. In a more recent analysis of single payer in California (2005), Lewin used more generous estimates of 22% for hospitals and 30% for physicians' offices. Mathematica Policy Research Inc. used more conservative estimates of 15% each for Maine. Ken Thorpe used estimates of 28% for hospitals and 26% for physicians. In this analysis, we used a middle of the road estimate of a 25% reduction for hospital and physician administrative savings under a single-payer system. We also assume that any administrative cost savings could be recouped entirely through reduced provider payments and reduce provider fees accordingly.

Uncompensated Care: We estimate current uncompensated care costs in New York State at \$3.0 billion. We derived this number using the MEPS 2004 Household Component for all full-year and part-year uninsured. As single payer would cover all residents of New York, we assumed that all uncompensated care cost payments would be eliminated under single payer coverage.

Building Block Plans (Variation 1 and Variation 2)

Public Program Expansions (Child Health Plus and Family Health Plus): For each of the public program expansions modeled under this scenario, we first estimated the population that is *currently* eligible for coverage based on New York State Medicaid eligibility rules. For example, we assume that any child under the age of 19 whose household income falls beneath 250% of the federal poverty level is eligible for Child Health Plus. We assume that all adults between the ages of 19 and 64 with zero children in their households and whose household incomes were below the poverty level were eligible for Family Health Plus. We assigned participation rates for each program by income group based on current enrollment by each population in the Medicaid program. We then estimated the populations that become *newly* eligible for the programs due to the eligibility expansions and assigned the observed participation rates (based on the behavior of already eligible groups) to that population in order to estimate take-up in the programs. We find participation rates for Child Health plus to be 80%, participation by childless adults for Family Health Plus to be 41% and participation by parents in Family Health Plus to be 60%.

We assume that existing providers would take any number of new FHP and CHP enrollees at current payment rates.

Family Health Plus Buy-In: We assumed that all adults who did not have government-sponsored insurance coverage and whose household incomes fell between 150 and 300% of the federal poverty level would be eligible for the buy-in. The eligible population included all the uninsured adults, those with employer-sponsored insurance (ESI), and those holding individual (non-group) coverage. Premium subsidies were assigned on a sliding-sliding scale basis according to the following distribution:

Variation 1 (Blueprint Proposal)

151 – 200% FPL: 80% subsidy
201 – 250% FPL: 65% subsidy
251 – 275% FPL: 50% subsidy
276 – 300% FPL: 25% subsidy

Variation 2

201 – 250% FPL: 80% subsidy
251 – 300% FPL: 60% subsidy
301 – 400% FPL: 40% subsidy

We separated uninsured adults eligible for the buy-in by who had an ESI offer and those without an offer. We estimated the percentage of uninsured adults with an offer using the Household Component of the 2004 Medical Expenditures Panel Survey (MEPS). We estimate that approximately 27% of the uninsured (including dependents and children) have an offer for employer-sponsored insurance and approximately 24% of adult uninsured (including dependents) have an offer. Individuals with an offer of insurance would compare the individual buy-in to the employee share of the ESI premium in deciding whether to take up coverage through FHP.

In order to estimate take-up of the buy-in by the uninsured, we used our estimates for take-up elasticity (derived from our uniform price elasticity estimates) and applied them, along with the

estimated change in price, to the uninsured population by income range. Table XIV lists all our take up elasticity estimates for adults, children and overall by poverty level.

There is little empirical evidence available that suggests that employers significantly drop coverage with the availability of new public programs, such as Medicaid.³³ Therefore, we assume that only employers of firms with fewer than 10 employees would drop coverage with the availability of this buy-in or the public program eligibility expansions, although individual employees might drop coverage and switch to public.

Insurance Connector: We assumed that participation in the connector would reduce individual insurance premiums by 5% (a generous estimate) based on analysis of existing literature.³⁴

Individual Mandate: Under the individual mandate, we assumed that 75% of these remaining uninsured after implementation of the public program expansions, the buy-in, and the insurance connector would enroll in the cheapest coverage available to them. We used the same methods to approximate the number of uninsured adults with an ESI offer as we had done for the buy-in, and assumed that 75% of this population would accept the offers. We assumed that of the remaining uninsured, all adults below 150% (200% under variation 2) of the federal poverty level would be eligible for Family Health Plus/Medicaid, all adults above 150% (200 under variation 2) FPL would become eligible for the buy-in, all children below 400% would be eligible for Child Health Plus/Medicaid, and children above 400% would be eligible only for individual or non-group coverage. 75% of each of these populations would take up the respective insurance that they would be eligible for under the mandate.

Building Block Plan (Variation 3)

Assumptions about Child Health Plus and Public Program Simplification: In the analysis of their Cornerstone plan, the Community Service Society of New York State assumed that measures to simplify eligibility and enrollment procedures in New York State's existing public programs (Family Health Plus and Child Health Plus) along with expansions of Child Health Plus eligibility levels to 400% FPL were already put into place. Thus, their estimates did not include the costs and coverage of these populations.³⁵ For our analysis, we assume that the Child Health Plus expansion had already occurred.

Public Program Expansion: We estimated take-up of the program using price elasticity estimates to derive take-up elasticity based on the estimated price change by income level. We assumed that after the Child Health Plus expansions, all remaining uninsured children and adults, and all privately insured individuals up to 600% of the federal poverty level were eligible for public coverage with sliding scale premiums. Premiums were assigned based on an individual's household income according to the following distribution:

Individual Coverage:

0 – 160% FPL: 0% (Free)
161 – 225% FPL: 1.4%
226 – 250% FPL: 1.6%
251 – 300% FPL: 2.4%
301 – 350% FPL: 2.8%
351 – 400% FPL: 3.5%

401 – 500% FPL: 4.3%
501 – 600% FPL: 4.7%
>600% FPL: Full Premium

Family Health Plus Employer Buy-In: Unlike the first two variations of the Building Block options, the third variation offers employers the option of buying public coverage for their employees. We assumed that all the working uninsured would be eligible for an employer buy-in to public coverage. Each individual would compare the full average ESI premium (employee and employer share) and the subsidized cost of coverage in the program (individual co-premium + employer share). We assume that employers would pay no more than 70% of the premium for coverage into the program. In effect, this treats each worker as a firm with one employee, individually making the decision of whether or not to offer public coverage. Hence, under the plan, buy-in occurs at the employer rather than the employee level.

Market-Based Plan

Repeal Community Rating and Guaranteed Issue Laws in the Non-Group Market: We estimated the coverage impact of repealing all of New York State’s community rating laws in the individual market using existing estimates of the effect of non-group community rating on insurance coverage by age and health status. We assumed that repealing community rating laws shift coverage from people who report having poor health to people who report having excellent health. Among the uninsured in excellent health, coverage would increase by 2.5%. However, the number of uninsured with poor health who enrolls would decrease by approximately 5.9%.³⁶ We used these estimates and the age/health-rated medical care costs for this group to create a distribution of percent change in coverage among the uninsured by age and health status (excellent, very good, good, fair and poor) as reported in our three-year CPS data. The net increase in coverage is due primarily to take up by the uninsured with reported excellent health.

Eliminate Benefit Mandates in the Non-Group Market: We used State-level 2005 estimates of average increase in the cost of premiums due to benefit service mandates put out annually by the Council for Affordable Health Insurance (CAHI) in order to calculate the percentage of total insurance costs attributed to benefit mandates by state.³⁷ In 2005, we assume that New York State’s benefit mandates accounted for approximately 20% of premium costs (assuming that policies would not have offered the mandated benefits prior to implementation of the mandate).

We ran a linear regression using the CAHI data to adjust for the size of the relevant mandates, to find the effect of the cost of benefit mandates on non-group enrollment. We controlled for the percentage of individuals that reported being self-employed and the percentage of people reporting having worked in the fishing, agricultural, forestry or hunting industries the previous year. Based on our regression coefficient, which suggested that an increase in benefit mandate costs would actually generated a slight *increase* in non-group enrollment, we assume that a one percentage point increase in the cost of benefit mandates would lead to no more than a 0.01 percentage point reduction in non-group coverage. The original Manhattan Institute proposal suggested eliminating only needless mandates. As we did not have a way to identify these, we modeled the effects of eliminating all service mandates.

High-Risk Pool: We derived estimates of medical care costs for the non-group and uninsured populations by age and health status. We assumed that this population who had medical costs

greater than the average New York State non-group premium (in the absence of community rating) would be eligible for a high-risk pool. We applied take up elasticity estimates to calculate the newly insured through the pool, assuming that each enrollee would have to pay 150% of this premium in the pool (\$4,500) and assumed that all eligible non-group enrollees would enter the pool, since they would be receiving equivalent care for a cheaper price. We then estimated the population of New York State in the non-group market and small-group market (assumed to be people with employer-sponsored insurance or their dependents who work for firms with fewer than 100 employees) and charged these populations a tax to cover the population eligible for the high-risk pool. A tax would not be charged to the privately insured in the large group market due to ERISA. We then used the price elasticity in conjunction with the estimated price change for the non-group and small-group market in order to estimate the decrease in coverage due to the addition of the tax.

We also offered the remaining uninsured population, i.e. those with lower medical costs and greater health statuses, a product in the non-group market. The product would offer coverage at their age-rated medical costs plus the tax for those in the high-risk pool.

Section 125 Plan: We used data from the 2005 Employee Benefits Survey of the Bureau of Labor Statistics in order to estimate the percentage of workers who have access to Flexible Benefit (cafeteria) plans. Currently, about 20% of all full-time workers have access to such plans. Under the proposal, we assume that 75% of firms that do not offer would comply with a mandate to do so, similar to our assumption for the individual mandate in the building block proposals.

We assumed that the workers with employer-sponsored insurance (ESI) who do not have access to these plans would be offered one under the proposal and that all offered would take up the plan. We used an estimate for New York State's marginal Federal and State tax rate to calculate the cost to the federal and state government, in effect treating the cafeteria plan as a tax credit or premium subsidy.

We also assumed that the uninsured population with an offer of ESI and workers with no ESI offer would be eligible to take up coverage if a cafeteria plan were offered. We modeled take-up using the estimated price changes for this population, the calculated Federal and State costs using the marginal tax rate estimates and the price elasticity assumptions detailed above. We assumed that the private insurance market would develop mechanisms to sell coverage through payroll deduction to non-offering employers with Section 125 plans.

Temporary / Short-Term Insurance Coverage: There is little public data available on the take up of temporary insurance. We were unable to retrieve any such data from any state's health commissioner, insurance department, or short-term insurance carriers. Consequently, we used data from the 2007 Annual Report of the Florida Office of Insurance Regulation, which contained data on enrollment in short-term medical insurance.³⁸ We applied the Florida take-up rate, 0.1% of the population, to New York State. As there was no data available on the composition of these enrollees, we distributed take-up proportionally among the non-group and uninsured populations.

Table XV: Parameters Used In Modeling of Proposals

Parameters	Estimate	Source
Uniform		
Per Capita (enrollee) Health Expenditure Inflation factors for Medical Expenditure Panel Survey (MEPS) by source of payment (for all services) to New York State		Author's estimates based on Centers for Medicare and Medicaid Services (CMS) National Health Accounts, 2004.
Medicare	1.86	
Medicaid	4.77	
Non-Medicare, Non-Medicaid	1.57	
Per Capita (enrollee) Health Expenditure Inflation factors for MEPS by source of payment (excluding nursing home care, non-durable medical products, and 'other personal health care') to New York State		Author's estimates based on CMS National Health Accounts, 2004.
Medicare	1.75	
Medicaid	3.00	
Non-Medicare, Non-Medicaid	1.40	
Payer Administrative Costs as a percentage of total personal health care benefit payments		CMS 2004.
Medicare	3.5%	
Medicaid	7.5%	
Private Insurance	15.3%	
Price Elasticity of Demand for Health Insurance		Author's estimates based on analysis of existing elasticity estimates.
<200% FPL	-0.3	
>200% FPL	-0.15	

Parameters	Estimate	Source
Full Individual (Loaded) Average Premiums for Health Insurance		
Family Health Plus	\$3,545	New York State Department of Health.
Child Health Plus	\$1,040	Kaiser Family Foundation, "State Health Facts".
Cornerstone Coverage	\$3,190	Weighted Average of FHP and CHP Premium.
Non-Group Coverage	\$8,178	New York State Insurance Department Premium Rates Index.
Health NY Coverage	\$1,908	New York State Insurance Department, 2006 Annual Report on the Healthy NY Program.
Average Employer-Sponsored Insurance Premium	\$3,391	MEPS 2004, Household Component, New York State.
Employee Share (Total)	\$680	
Percentage of Uninsured with an offer of insurance through their employer	27%	Author's estimates based on analysis of MEPS 2004, Household Component.
Adults	24%	
Crowd-Out Rate Assumptions		
Previously Non-Group	80% Take Up	
Previously Employer-Sponsored	Take-Up Elasticity 30% as high as for uninsured	Glied, Zivin, Remler, "Inside the Sausage Factory".
Overall Take Up Elasticity Estimates for Building Block Plans		Author's calculations. Price elasticity estimates were multiplied by the ratio of privately insured to uninsured New Yorkers in each cell in order to calculate take-up elasticity. Multiplying these take up elasticities by estimated price change for insurance at each levels
0 – 150% FPL:	0.27	
151 – 160% FPL:	0.57	
161 – 200% FPL:	0.75	
201 – 225% FPL:	0.51	
226 – 250% FPL:	0.55	
251 – 275% FPL:	0.83	
276 – 300% FPL:	0.99	

Parameters	Estimate	Source
301 – 350% FPL: 351 – 400% FPL: 401 – 500% FPL: 501 – 600% FPL: >600% FPL:	0.99 1.19 2.23 2.41 3.29	<p>yielded a take-up rate for the uninsured. These elasticity estimates imply that a 10% reduction in the price of coverage would lead to a 5.7% increase in enrollment (between 151 and 160% FPL).</p> <p>At higher income levels, there are fewer uninsured persons and more with employer-sponsored insurance (ESI), which led to greater elasticity estimates at these levels. We cap all take-up rates at 90%--that is, we assume that for coverage at a price of zero, no more than 90% of a population would voluntarily enroll.</p>
Adult Take Up Elasticity Estimates for Building Block Plans 0 – 150% FPL: 151 – 160% FPL: 161 – 200% FPL: 201 – 225% FPL: 226 – 250% FPL: 251 – 275% FPL: 276 – 300% FPL: 301 – 350% FPL: 351 – 400% FPL: 401 – 500% FPL: 501 – 600% FPL: >600% FPL:	0.21 0.44 0.58 0.42 0.45 0.66 0.82 0.81 1.04 1.93 2.05 2.86	<p>Author's calculations. Price elasticity estimates were multiplied by the ratio of privately insured to uninsured New Yorkers in each cell in order to calculate take-up elasticity. Multiplying these take up elasticities by estimated price change for insurance at each levels yielded a take-up rate for the uninsured. These elasticity estimates imply that a 10% reduction in the price of coverage would lead to a 4.4% increase in enrollment (between 151 and 160% FPL).</p> <p>At higher income levels, there are fewer uninsured persons and more with ESI, which led to greater elasticity estimates at these levels. We cap all take-up rates at 90%--that is, we assume that for coverage at a price of zero, no more than 90% of a population would voluntarily enroll.</p>
Adult Take Up Elasticity Estimates		Author's calculations. Price

Parameters	Estimate	Source
for Building Block Plans		elasticity estimates were multiplied by the ratio of privately insured to uninsured New Yorkers in each cell in order to calculate take-up elasticity. Multiplying these take up elasticities by estimated price change for insurance at each levels yielded a take-up rate for the uninsured. These elasticity estimates imply that a 10% reduction in the price of coverage would lead to a 5.0% increase in enrollment (between 0 and 150% FPL).
0 – 150% FPL:	0.50	
151 – 160% FPL:	1.43	
161 – 200% FPL:	1.58	
201 – 225% FPL:	1.08	
226 – 250% FPL:	1.30	
251 – 275% FPL:	1.93	
276 – 300% FPL:	1.77	
301 – 350% FPL:	2.01	
351 – 400% FPL:	1.86	
401 – 500% FPL:	3.78	
501 – 600% FPL:	5.08	
>600% FPL:	7.12	
Single Payer Plan		
Single Payer Administrative Costs as a percentage of total personal health care benefit payments	5%	Estimate between Medicare and Medicaid administrative costs.
Provider Administrative Costs as a percentage of expenditures		Lewin Group, <i>O Canada, Do We Expect Too Much...</i> , 1992.
Hospital	33%	
Physician & Clinical	31.6%	
Reduction in provider administrative costs due to single payer simplifications		Assumption based on existing literature.
Hospital	25%	
Physician and Clinical	25%	
Increase in total health care expenditures for the privately insured population due to a 25% reduction in cost-sharing		RAND Health Insurance experiment. <i>Free-for-All</i> , pg. 48.

Parameters	Estimate	Source
Children (0 – 18)	20.7%	
Adults (19+)	23.8%	
Percent of Medicare population without supplemental insurance	12%	Kaiser Family Foundation, Medicare Chartbook, 2002.
Increase in Medicare expenditures due to an increase in utilization by Medicare population without supplemental insurance.	6.7%	Adam Atherly, <i>The Effect of Medicare Supplemental Insurance on Medicare expenditures</i> , 2002.
Building Block Plans		
Participation Rates for Existing Public Programs		Author's estimates based on Current Population Survey 2004 – 2006.
Family Health Plus		
Childless Adults	41%	
Parents	60%	
Child Health Plus	80%	
Take Up Rates for Individual Mandate	75%	Assumption
Non-Group Premium Reduction due to Implementation of an Insurance Connector	5%	Assumption
Percentage of Remaining Premium Cost Paid for by Employer after Employee Share (Employer Buy-In Option)	< 70% of full premium	Community Service Society, <i>Cornerstone for Coverage</i> , 2007.
Market-Based Plan		
Average Percent Change of Uninsured Due to Repealing Community Rating Laws		Lo Sasso, Lurie, <i>Community Rating and the Market for Non-Group Health Insurance</i> , 2007.
Excellent Health	+2.5%	
Poor Health	-5.9%	
Percentage of Insurance Costs Attributed to Benefit Mandates	20%	Author's estimates based on data from the Council for Affordable Health Insurance, <i>Health Insurance Mandates in the States</i> , 2005.
Percentage Point Change in Non-Group Insurance Due to a Percentage Point Increase in Benefit Mandate Costs	-0.01	Author's estimates based on data from the Council for Affordable Health Insurance, <i>Health Insurance Mandates in</i>

Parameters	Estimate	Source
		<p><i>the States</i>, 2005 and regression.</p> <p>Our regression result indicated a slightly positive coefficient. We therefore assume a modest effect of benefit mandates on non-group enrollment of 0.01 percentage points. (a 1 percentage point increase in benefit mandate costs lead to a 0.01 percentage point decrease in non-group coverage).</p>
Percentage of Workers (Full-Time) with access to Flexible Benefit (cafeteria) Plans	20%	Bureau of Labor Statistics, Employee Benefit Survey, 2005.
New York State Marginal Tax Rates		Author's estimates based on National Bureau of Economic Research Average Marginal Income Tax Rates since 1977. We used ½ of the Social Security marginal tax rate in our calculations, as the employer bears half this cost.
Federal State Social Security	19% 6% 14%	
Take Up Elasticity Estimates for Section 125 Plans (by Poverty Level) <100% FPL 100 – 199% FPL 200 – 299% FPL: 300 – 399% FPL: >400% FPL:	0.04 0.06 0.06 0.15 0.49	Author's calculations. Price elasticity estimates were multiplied by the ratio of full-time working insured with no ESI offer to the working uninsured with no offer in order to calculate take-up elasticity. Multiplying these take up elasticities by estimated price change for insurance at each levels yielded a take-up rate for the uninsured. These elasticity estimates imply that a 10% reduction in the price of coverage would lead to a 0.6% increase in enrollment (between 200 and 299% FPL).
Take Up Elasticity Estimates for High-Risk Pool (By Age) 0 – 18 19 – 24 25 - 34	0.07 0.01 0.02	Author's calculations. Price elasticity estimates were multiplied by the ratio of people with non-group coverage to the uninsured eligible for the pool. We

Parameters	Estimate	Source
35 – 44	0.01	calculated elasticities for the pool by age as an individual's medical costs and eligibility for the pool were dependent on age and health status.
45 – 54	0.03	
55 - 64	0.04	

**Table XVI: Review of Previously Published Estimates for
"Building Block" and "Cornerstone" Proposals for New York State**

Paper	Reforms Modeled	Eligible Population	Newly Insured	Crowd-Out*	Costs
"Building Block" Reform					
United Hospital Fund and The Commonwealth Fund, "A Blueprint for Universal Health Insurance Coverage in New York" (2006).	1) Public Program Streamlining and Simplification 2) Family Health Plus Expansion for Childless Adults 3) Family Health Plus Buy-In / Insurance Connector with Premium Subsidies 4) Employer Assessment / Pay-or-Play 5) Individual Mandate	1) Childless adults under 150% FPL 2) Individuals with incomes between 150% and 300% FPL 3) Employers with 10 or more workers 4) All remaining uninsured (individual mandate)	840,000 (without mandate) 2.4 million (with employer and individual mandate)	1.7 million (without mandate) 1.3 million (with modest assessment for employers and mandate) 600,000 (with pay-or-play and mandate)	<u>Without Mandate</u> Net: \$1.7 billion State: \$4.8 billion <u>With Mandate (modest assessment scenario)</u> Net: \$4.1 billion State: \$5.5 billion <u>With Mandate (pay-or-play scenario)</u> Net: \$4.1 billion State: \$4.0 billion
Our Results	1) Child Health Plus Expansion 2) Family Health Plus Expansion 3) Family Health Plus Buy-In 4) Insurance Connector 5) Individual Mandate	1) Children under 400% FPL 2) Childless adults Below 150% FPL 3) Adults between 150 and 300% FPL 4) Remaining Uninsured (Mandate)	500,000 (without mandate) 2.1 million (with mandate)	300,000 (without mandate) 300,000 (with mandate)	<u>Without Mandate</u> Net: \$900 million State: \$1.0 billion <u>With Mandate</u> Net: \$5.0 billion State: \$4.0 billion

Paper	Reforms Modeled	Eligible Population	Newly Insured	Crowd-Out*	Costs
"Cornerstone" Reform					
Community Service Society, "Cornerstone for Coverage" (2007).	1) Universal access to FHP/CHP Public Program 2) Employer Buy-In	All residents of New York State	888,000	914,000	State \$4.4 billion
Our Results	1) Child Health Plus Expansion 2) Universal access to FHP/CHP Public Programs 3) Employer Buy-In	1) Children under 400% FPL 2) All residents of New York State	1.0 million	500,000	Net \$1.6 billion State \$3.6 billion

* Our crowd-out estimates vary significantly from the United Hospital Fund and The Commonwealth Fund "Blueprint" study, as we do not model an employer buy-in or assume that most employers would drop insurance coverage with the availability of Family Health Plus at higher eligibility levels. In addition, we do not model public program simplification or streamlining measures.

Notes

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² Elisabeth Ryden Benjamin, Arianne Garza, “Cornerstone for Coverage: Towards a Universal Health Plan for New York,” December 2007,
http://www.cssny.org/userimages/downloads/CornerstoneforCoverageLongIslandHearings_dec51.pdf

³ Tarren Bragdon, “Rx NY: A Prescription for More Accessible Health Care,” December 2007.

⁴ A description of the Urban Institute’s modeling parameters is available at
http://www.partnership4coverage.ny.gov/reports/modeling_instructions_2008-06-30.htm.
“Modeling of Options for Expansion of Health Insurance Coverage for New Yorkers,” June 30, 2008.

⁵ Physicians for a National Health Plan, “Specifications of Single Payer Options for Urban Institute Study,” February 2008.

⁶ Benjamin, “Cornerstone for Coverage”.

⁷ Ibid.

⁸ Bragdon, “Rx NY: A Prescription for More Accessible Health Care”.

⁹ United States Census Bureau and Bureau of Labor Statistics, Current Population Survey Annual Social and Economic Study Supplement, 2004 – 2006.

¹⁰ Agency for Healthcare Research and Quality, Medical Expenditures Panel Survey, Household Component, 2004.

¹¹ Centers for Medicare and Medicaid Services, “National Health Expenditure Data,” State Estimates by State of Residence, 2004 [accessed May 2008].

¹² Sherry Glied, Dahlia K. Remler, Joshua Graff Zivin, “Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals,” *The Millerbank Quarterly*, Vol. 80, No. 4 (2002), pp 603-605.

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