THREE STEPS TO AFFORDABLE HEALTH COVERAGE FOR NEW YORK'S EMPLOYERS.

POLICY BRIEF

Expanding Affordable Coverage for Low-Waged Workers

Fixing the Family Health Plus Employer Buy-In

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POLICY BRIEF

EXPANDING AFFORDABLE COVERAGE FOR LOW-WAGED WORKERS: Fixing the Family Health Plus Employer Buy-In

By Elisabeth R. Benjamin & Arianne Garza

This Policy Brief describes how New York can provide affordable, comprehensive health coverage to employees of small businesses, other employers, unions, and sole proprietors by restructuring a little-known program called the Family Health Plus Employer Buy-In (EBI). If adopted, these program improvements would also help small businesses in New York to leverage significant tax credits offered under the new federal health reform law.

Originally adopted in 2007, the EBI program made New York's popular and comprehensive Family Health Plus (FHP) program available to employers and union benefit funds on a buy-in basis. Employers participating in the program pay 70 percent of premiums, while covered employees pay the remaining 30 percent. Additionally, the State may pay the employer's share of the premium for low-income employees eligible for FHP, and it currently does so for more than 40,000 home care workers in the Service Employees International Union, Local 1199 (1199-SEIU)—the only program participants at this time.

While the market for the EBI program is potentially significant, no employers have enrolled in the program. Of uninsured working New Yorkers, 1.1 million have moderate or low incomes falling below 300 percent of the Federal Poverty Level (FPL), or about $55,000 for a family of three. More than 40 percent of uninsured workers are employed at firms with fewer than 25 employees. Most small businesses cannot provide health coverage because of cost concerns. Those that do spend on average 18 percent of their payroll on health coverage.

Stakeholders agree that the current premiums in the EBI program are too expensive to attract any employers. For example, the individual premium rate for New York City is $541 per month: 5 percent higher than the average small group premium; 30 percent higher than the restricted benefit cover-

The Community Service Society of New York (CSS) is an informed, independant, and unwavering voice for positive action that serves the needs of low-income New Yorkers.

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age available in the Healthy NY program; and 69 percent higher than the subsidized 1199-SEIU EBI rates. Unresolved operational issues have further delayed the program's expansion. As a result of the costs and operational concerns, only one insurance plan has agreed to offer the program to new enrollees.

By adopting the recommendations in this brief, the State could reduce the EBI health insurance premium for employers by as much as 55 percent, from $541 to $242 per employee per month.

The EBI premiums can be reduced significantly by the adoption of three changes. *First*, the program could adopt modest co-payments (similar to those proposed in the 2010-2011 Executive Budget). *Second*, the program could switch from using higher commercial provider reimbursement rates to lower hybrid or public provider reimbursement rates by targeting the program to the uninsured. This second change could be achieved in three steps: (1) adopt public insurance rules for taxes and assessments; (2) adopt the Medicaid default rate for emergency, out-of-network care; and (3) adopt an anti-crowd-out rule. *Third*, the EBI program could access the Healthy NY stop-loss pool for small businesses.

Independent actuaries hired by New York State and the Community Service Society (CSS) agree that the combination of just the first two steps would cut premiums by approximately 35 percent (from $541 to $345 per individual per month). The premium costs for many small employers would be further reduced by the new federal health reform law, which provides up to 35 percent of premiums in tax credits to qualifying small businesses and not-for-profits with fewer than 25 employees and moderate-income workers. With the federal tax credit, a small business could pay as little as $157 per month and the employee would pay $104 per month for comprehensive health coverage. Premiums could be further reduced by allocating Healthy NY funds to the EBI program.

Background

For the past decade, increases in employer-sponsored insurance premiums have led to declines in health coverage amongst low-waged workers.[1] Some states have sought to address this problem by developing hybrid public/private insurance models.[2] These models have taken various forms, ranging from new insurance products, such as Washington's Basic Health program, to using state funds to purchase private coverage for low-waged workers. A summary chart detailing some of these state-based models is displayed in Appendix I of this Policy Brief.

Legislative History, Program Goals & Market Potential

Perhaps mindful of other state-based efforts, in 2007, the New York State legislature enacted a hybrid public/private insurance program of its own: the Family Health Plus

Methodology

The findings of this Policy Brief are based on original policy research performed by the Community Service Society (CSS) and an actuarial analysis performed by Gorman Actuarial (GA), at CSS's request.

GA analyzed the State's actuarial rate setting process which was derived from a downstate commercial insurance plan. GA then rebuilt the State's premium rates using claims data acquired from the New York State Department of Insurance, and worked closely with CSS to test various alternatives for reducing the premiums in the EBI program. See Appendix II.

CSS conducted a 50-state analysis of hybrid programs; reviewed existing research concerning the market and potential take up (or adoption) of the EBI program by New York employers; interviewed key informants in New York and nationally; and analyzed the impact of various benefit and design adjustments on the State's rate-setting process. Our findings were reviewed and discussed at two stakeholder meetings, convened by the New York State Health Foundation in New York City and Albany, with elected officials, representatives from the Governor's administration, insurance plan, business, and labor representatives, policy experts, and other key stakeholders.

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Employer Buy-In program (EBI).[3] Under the law, employers and union benefit funds are able to purchase coverage for workers through New York's popular and comprehensive Medicaid expansion program, known as Family Health Plus (FHP). At the time of enactment, lawmakers had three main goals for the program: (1) reduce the number of uninsured New Yorkers; (2) provide a low-cost coverage alternative to employers; and (3) provide subsidized coverage for special groups (e.g., 1199-SEIU and other unions).

The market for the EBI program in New York is potentially significant. Employee health coverage has been steadily declining for years as insurance premium rates have catapulted well beyond the rate of medical inflation. For instance, between 2000 and 2009, insurance premiums for job-based health insurance rose by 97 percent in New York,[4] while median worker earnings only grew by 14 percent.[5] Insurance on the individual (or "Direct Pay") market has followed suit with average annual increases of 15 percent.[6] In some New York counties, single-year rate increases have been as high as 51 percent.[7] The cost of health insurance for a family on the Direct Pay market now exceeds $24,000 annually.[8]

Due to the combination of declining employer health coverage and unaffordable prices in the individual market, New York's uninsured population consists largely of working people and their dependents. These working families comprise 80 percent (two million) of the State's total uninsured.[9] The majority of uninsured workers are lower income: 810,000 earn less than 200 percent of FPL; another 294,000 earn between 201–300 percent of FPL.[10] And, while New York has taken significant strides to expand public insurance programs, many low-income workers remain above eligibility levels.

Small businesses (those with less than 100 employees), which do not have the bargaining power of their larger counterparts, have had the greatest difficulty in absorbing the growing cost of health coverage. In New York, small businesses now spend an average of 18 percent of their payroll on health insurance costs, if they are able to offer it at all.[11] More than 40 percent (805,000) of uninsured workers are employed at firms with less than 25 employees (of which 175,000 are sole-proprietors).[12]

All of this indicates a significant market failure on behalf of the small group and individual insurance market, and a large potential customer base for this program. Healthy NY offers some reprieve for individuals and employers who meet the program requirements and are healthy enough to suffice with the limited benefit package. Yet, with two million working adults still uninsured, it is clear that Healthy NY alone cannot adequately address the needs of working low- and moderate-income New Yorkers.

How Does the EBI Work?

The State's regular Family Health Plus program offers a managed care insurance product to individuals who have in-

What is Healthy NY?

Created in 2000, Healthy NY is a state program that offers a limited benefit package to 160,000 New Yorkers through commercial insurance plans. Coverage is subsidized through a State-funded reinsurance pool which pays for 90 percent of medical claims between $5,000 and $75,000.

Targeting qualified small businesses, sole proprietors, and uninsured working individuals, the program offers limited benefits at a reduced cost to:

- Employed individuals and sole proprietors with incomes below 250 percent of FPL who are ineligible for other insurance.
- Small businesses with fewer than 50 employees, at least 30 percent of whom must earn less than $40,000 annually (370 percent of FPL).

Coverage under the Healthy NY program is subject to a 12-month anti-crowd-out waiting period. With some exceptions, enrollees must have been uninsured for 12 months prior to enrollment and there is a 12-month pre-existing condition exclusion.

The monthly premium for an individual in 2010 in New York City is around $360 per month. Due to its limited benefit package, it may not be considered a "qualified health plan" under the new federal health reform law—The Patient Protection and Affordable Coverage Act of 2010 (PPACA).

comes above the Medicaid limits. In 2010, for a childless individual to qualify, he or she must earn less than 100 percent of the federal poverty level (FPL), or $10,800 per year; an individual with a child under 21 years of age must earn less than 150 percent of FPL, or $21,850. The State establishes a single comprehensive benefit package that cannot be adjusted without a change in statute. As of May 2010, about 20 public (and a few private) insurance plans provide coverage to roughly 390,000 New Yorkers enrolled in FHP.[13]

The EBI program allows employers and unions to participate in the regular FHP program by buying into it on behalf of their employees or members.

Premiums: State law requires participating EBI program employers to pay at least 70 percent of the premium for all covered employees. The balance is paid by the employees. For those employees who have very low incomes, and would otherwise be eligible for regular FHP, the State pays the employee's share. In other words, the State pays the 30 percent co-premium for childless people under 100 percent of FPL or people with children under 150 percent of FPL. In either case, employers continue to pay the remaining 70 percent of the premium. The State may additionally subsidize the employer's (70%) share of the premium if: (1) the employer or union did not previously offer insurance coverage; or (2) if the employer or union's "ability" to offer health insurance coverage is in "jeopardy."[14] As described in detail below, the premiums are set by the State.

Enrollment: To qualify, all employees in the workplace must enroll into the program. Brokers are barred from selling this product. To enroll, an employer must fill out a one page application and submit it to the New York State Department of Health. On the form, the employer selects an insurance plan. The insurance plan will then facilitate the enrollment

TABLE 1
Cost-Sharing and Actuarial Values of Selected New York Insurance Products

	Small Group HMO/POS	Direct Pay HMO/POS	Healthy NY HMO	FHP Employer Buy-In
Inpatient Co-pay	$275	$500	$500	$25
PCP Office Visit Co-pay	$20	$15	$20	$3
Specialist Co-pay	$28	$15	$20	$3
ER Co-pay	$72	$50	$50	$3
Outpatient Surgery Co-pay	$63	$75	$75	$0
Radiology	-	-	-	$1
Lab	-	-	-	$1
Surgical Procedure: 20% up to $200	N	Y	Y	N
Mental Health/Substance Abuse	Y	Y	N	Y
Chiro, Ambulance, DME	Y	Y	N	Y
PHARMACY				
Generic	$10	$5	$10	$3
Brand	$25	$10	$20	$6
Non Formulary	$50	$10	$20	$6
Deductibles	-	$100	$100	-
Benefit Maximum	None	None	$3,000	None
ESTIMATED ACTUARIAL VALUE	**87%**	**92%**	**77%**	**98%**

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.

of the employees, determining who among them may be eligible to have the State pay their 30 percent portion.

Benefits: As originally designed, the EBI utilizes the standard FHP benefit package: employers and unions may not adjust the benefit package or cost-sharing. Its comprehensive benefit package has an actuarial value of about 98 percent. This means that the plan pays for 98 percent of the medical costs and the enrollee pays for the remaining 2 percent through out-of-pocket cost-sharing (in the form of co-payments). This is in sharp contrast to the products on the current small group market, which have an actuarial value of about 87 percent, the individual/Direct Pay market, which has an actuarial value of 92 percent, and Healthy NY, which has an actuarial value of 77 percent.[15] Many insurers fear that the EBI program's generous design may attract a sicker population (resulting in adverse selection), including some who may drop their current coverage in favor of the EBI program (known as "crowd out").

Implementation to Date

On April 1, 2008, a pilot EBI program, administered by Fidelis Care, was launched for 55,000 1199-SEIU home care workers. The State opted to subsidize the union's 70 percent share of the premium for this group. Since that time, primarily due to changes in union coverage rules (including eliminating spousal coverage and changes in numbers of hours worked to qualify for health coverage), enrollment has decreased to around 40,000 members.[16]

In August 2009, the New York State Department of Health released the premium rates with the intention of opening enrollment to employers in January 2010. The Mercer actuarial firm derived the premium rates using a commercial database as its baseline. In deriving the rates, the State and Mercer adopted a series of program design decisions, some of which treated the EBI program as a commercial product and others which treated the program as a public program (see Table 2). Cumulatively, these decisions increased the EBI program rates.

As a result, many stakeholders found Mercer's rates significantly higher than expected.[17] For example, the individual rate for New York City was set at $541 per month—approximately 5 percent higher than the average small group premium in New York State, 30 percent higher than the restricted benefit coverage available in the Healthy NY program, and 69 percent higher than the subsidized 1199-SEIU EBI rate. Due, in part, to these high premiums, no employers have signed up to participate in the EBI program.[18] And only one insurance company, Neighborhood Health Plan, has agreed to offer coverage beyond the Fidelis/1199-SEIU program.

Faced with no employer take-up and marginal plan participation, many stakeholders have determined that the program is at a crossroads and needs significant adjustments to realize its potential. This Policy Brief outlines concrete alternatives which could achieve significant premium reductions.

Conflicting Program Goals Lead to Product Uncertainty

The high premium rates developed for the EBI program are due, in large part, to conflicting goals that were used to guide the development of the program. As mentioned

Operational Issues

Premium rates are far and away the most significant point of contention for legislators, small businesses, and insurers. However, several stakeholders identified additional issues with the EBI program that require resolution, including:

- Concern that New York's Public Health Plans (PHPs) will have difficulty retooling their marketing staff, materials, and campaign to employers (as opposed to individuals).
- Concern that employers prefer to work with brokers rather than insurers directly. The use of brokers would increase premiums by 3–5 percent.
- Concern that employers would find the application and other enrollment procedures in the EBI program to be too cumbersome.
- Concern that employers would find the benefit administration (billing and reporting) too difficult.
- Concern that the PHPs do not have the claims processing and other technical capacity to administer the EBI program in the employer context.

earlier, the program was designed to be a hybrid public/private insurance product which would ideally fulfill three goals:

1. Reduce the number of uninsured New Yorkers;
2. Provide a low-cost alternative to employers; and
3. Provide subsidized coverage for special groups.

Despite good intentions, these goals proved to be at odds with each other when it came to product development and premium rate-setting. The first goal—covering the uninsured—implies that the program will be a public one, similar to its predecessor and namesake, Family Health Plus. The second goal—providing a low-cost alternative to employers and providing subsidized coverage for special groups—is reminiscent of the State's private health insurance expansion under Healthy NY.

When the EBI program was first implemented under the 1199-SEIU pilot, this conflict appeared to be resolved in favor of treating the program as a public program. A premium, initially around $320 per member per month, was developed after a review of 1199-SEIU's self-funded claims data. In addition, the health plan that was selected, Fidelis Health Plan, was able to negotiate public insurance reimbursement rates with its network providers. The State also did not impose some taxes and fees required of commercial products (described in greater detail below).[19]

As the State expanded the EBI program to employers and plans beyond the 1199-SEIU pilot and Fidelis, it again faced a series of design decisions. Attempting to strike a balance between competing program goals, the State adopted commercial rules for some features and public program rules for other program features (see Table 2). Several of these decisions had a significant impact on the EBI premiums. For example, in order to prevent providers from experiencing a drop in revenue due to commercially insured individuals dropping coverage for the EBI program, the State assumed that EBI plans would pay providers commercial rates. The State also decided to extend commercial taxes and fees to EBI products. These design decisions, combined with the rich FHP benefit package, served to ratchet the rates far beyond other commercial products.

TABLE 2
Uncertainty About Product Definition in the Family Health Plus Employer Buy-In Programs

EBI Commercial Features	EBI Public Program Features
• Commercial quality reporting rules.	• Public program quality reporting rules, encounter data, & operating reports.
• HCRA surcharge at commercial level.	• SDOH rate setting & other regulation.
• Section 332 assessments apply to premiums.	• Covered benefits and co-pays are equivalent to FHP.
• Covered lives assessment at commercial rate.	• No brokers allowed.
• Premium tax (may only apply to for-profit HMO, if applicable at all).	• Facilitated enrollers process applications for FHP-eligible people.
• No provider default rates.	• Certain people & services exempt from co-pays.
• No State-sponsored stop-loss coverage (inpatient/nursing home MMC, or Healthy NY).	• State administrative "fair hearings" are available for eligibility issues and Medicaid benefits outside the EBI benefit package.
• Pre-existing condition clauses.	• Public program eligibility documentation rules apply to enrollees.
• Draft rates are community rates and were developed using commercial reimbursement levels.	• Enrollment in EBI does not count toward enrollment in commercial products.
• Commercial due process (no fair hearings).	• Plans must use SDOH FHP therapeutic equivalents for pharmacy benefits.
• Member-to-provider ratios for commercial products apply.	• Potential State subsidy of employer share for subsidy-eligible enrollees (if they are deemed to be "in jeopardy" when offering coverage).
• Federally qualified health centers and presumptive eligibility providers do not need to be in the network.	
• Out-of-State employees can enroll.	

Discussion of Alternatives

Working with Gorman Actuarial and Manatt Health Solutions, CSS developed several alternatives to address prohibitive EBI premium rates. A significant premium adjustment can be achieved in three steps: (1) adjust the plan design; (2) target the program specifically to the uninsured; and (3) access existing State reinsurance funding through the Healthy NY stop-loss pool. Cumulatively, these changes would bring the premium cost down by as much as 55 percent.*

Step One: Adjust the Program Design

The premium price of an insurance product is largely determined by its actuarial value—or the amount the insurer pays for medical costs. Actuarial values fluctuate based on the benefit package and co-payments for services. The standard FHP program benefit package, which is currently offered to all EBI enrollees, has an actuarial value of 98 percent.[20] In the 2010–2011 Executive Budget, New York State proposed lowering the premium price for the EBI program by adjusting the cost-sharing to better reflect a typical employer-based insurance package, thereby decreasing its actuarial value.[21] This proposal would achieve roughly a 9 percent premium reduction.

Three Steps to Affordable, Quality Health Coverage

Step 1: Adjust the plan design (9 percent savings)

Step 2: Target the program to the uninsured and adopt Medicaid or hybrid provider reimbursement rates: (around 36 percent savings)

- ✔ Adopt public insurance rules for taxes and assessments
- ✔ Adopt the Medicaid default rate for Emergency Out-of-Network care
- ✔ Adopt an anti-crowd-out rule

Step 3: Access the Healthy NY stop-loss pool (30 percent savings)

*Note: These premium adjustments overlap with each other and cannot be directly summed.

The Massachusetts Commonwealth Care program uses a staggered cost-sharing structure based on enrollee income levels. A gradual increase in actuarial values over three income tiers means that enrollees with lower incomes pay smaller co-pays (if any) and enrollees with higher incomes pay higher co-pays for the same services. For example, the actuarial values for people at 100 percent of FPL, between 100 and 200 percent of FPL, and between 200 and 300 percent of FPL are 99 percent, 93 percent, and 89 percent, respectively (see Table 3).

While a three-tiered program like Commonwealth Care's would add significant administrative complexity to the EBI program, a two-tiered structure would be manageable and

TABLE 3
Massachusetts Commonwealth Care 2009 Plan Design

	Plan Type I <100% FPL	Plan Type II 100-200% FPL	Plan Type III 200-300% FPL
Inpatient Co-pay	$0	$50	$250
PCP Office Visit Co-pay	$0	$10	$15
Specialist Co-pay	$0	$18	$22
ER Co-pay	$0	$50	$100
Outpatient Surgery Co-pay	$0	$50	$125
Radiology	-	$0	$0
Lab	-	$0	$0
Surgical Procedure: 20% up to $200	N	N	N
Mental Health/ Substance Abuse	Y	Y	Y
Chiro, Ambulance, DME	Y	Y	Y
PHARMACY			
Generic	$1	$10	$12.50
Brand	$3	$20	$25
Non Formulary	$3	$40	$50
Deductibles	-	-	-
Maximum Copay Pharmacy/Medical	$200/$0	$500/$750	$800/$1500
ACTUARIAL VALUE	**99.5%**	**93%**	**89%**

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.

still help bring down premiums by 9 percent. After consultation with State Department of Health officials, CSS recommended that the State adjust its 2010–2011 Executive Budget proposal to reflect the cost-sharing schedule (including an annual cost-sharing cap of $2000) displayed in Table 4.

Adjusting the benefit package would essentially create two plan designs based on enrollee income level:

- "Option A" (with the current 98 percent actuarial value) for those employees who are eligible for regular FHP (or who earn less than 100 per cent or 150 percent FPL); and
- "Option B" (with a lowered actuarial value of 89 percent) for those earning above the regular FHP eligibility income limits.

Two plan designs are essential because the very low-income subsidized EBI members must maintain equivalent coverage as their counterparts in the regular FHP program—otherwise they would be unfairly penalized by their employers' choice to participate in the EBI program (when they could enroll directly into regular FHP with almost no cost-sharing on their own).

Under the new benefit design, employers would pay for 70 percent of the cost of Option B for all employees. The remainder would be paid by either the State (for the subsidized population) or by the employee. In order to keep the program simple for employers, and because Option A has a higher actuarial value, the State will in effect be paying the difference between Option A and what the employer pays. For example, in Table 5, for State-subsidized individuals, the State pays $196 for the higher-valued FHP package of $540 (Option A) and the employer only pays for the lower-valued Option B benefit package, which is valued at $492. For non-subsidized individuals, the employers share is still $492. The end result is a State subsidy of 36 percent for lower-income employees, whereas higher-income employees will be contributing only 30 percent (see Table 5).

TABLE 4
Proposed Adjustment to Benefit Package for Non-Subsidized Enrollees

Income Level	<150% FPL	>100%/150% FPL
	Option A	Option B
Inpatient Copay	$25	$150
PCP Office Copay (OP, MH, SA)	$5	$10
Specialist Copay	$5	$25
ER Copay (for non-emergencies)	$3	$50
Outpatient Surgery Copay	$0	$100
Radiology	$1	$10
Lab	.50¢	$10
PHARMACY		
Generic	$3	$5
Brand	$6	$15
Non Formulary	$6	$15
No deductibles or max benefit		
Annual Co-Payment Cap	n/a	$2000
ESTIMATED ACTUARIAL VALUE	98%	89%
Rate Difference		-8% or -9%

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.

TABLE 5
Employer/Employee Cost-Sharing Under Plan Adjustment

	Income Level	Option A State-Subsidized Rate	Option B Non-State Subsidized Rate	Employer Contribution (70%)	Employee Contribution (30%)	State Subsidy (36%)
Childless Adults Subsidized	<100% FPL	$541	$492	$345	$0	$196
Parents Subsidized	<150% FPL	$541	$492	$345	$0	$196
Unsubsidized Employee	>100/150% FPL	-	$492	$345	$147	$0

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.

Note: Numbers may not sum due to rounding.

While changes in the benefit design yield a marginal decrease in the EBI premium, they alone are not enough to make the program affordable to employers or most low- and moderate-waged workers. Parents earning just over 150 percent of FPL would be required to pay $148 per month for premiums alone, or more than 8 percent of their gross annual income, and even more when considering co-payments. Childless enrollees just above 100 percent of FPL would be required to pay as much as 16 percent of their gross annual income for premiums alone.

Accordingly, because the 9 percent reduction in premiums will not generate sufficient savings for employers, and may unduly harm low-waged workers, additional steps to fix the EBI program must be taken.

Step Two: Target the Program to the Uninsured

Targeting the EBI program to the uninsured would significantly reduce premium costs. Doing so would also give the Department of Health a stronger basis for designating the EBI as a public program, and would drive the premium prices down by as much as 25 percent. There are several changes that support this approach: (1) reducing taxes and assessments on the EBI program; (2) adopting the Medicaid default rates for emergency room and out-of-network utilization; and (3) adopting an anti-crowd-out provision that would allow plans to negotiate provider reimbursement rates that more closely align with the existing FHP program.

Adopt Public Insurance Rules for Taxes/Assessments. EBI products for participants other than the Fidelis/1199-SEIU pilot currently are subject to several State Departments of Health and Insurance taxes and fees. While the Fidelis/1199-SEIU EBI pilot program was designated as a public product, the State since determined that the EBI program is a commercial product and consequently subject to all commercial taxes and fees (see Table 6).

Should the State apply public insurance rules for taxes and assessments to the EBI program, the HCRA surcharge would be reduced by 1.3 percent and both the Covered Lives Assessment and the Section 332 Insurance Department Assessment would be eliminated. Cumulatively, this would reduce EBI premiums more than 5 percent (see Table 7).[26]

Adopt the Medicaid Default Rate for Emergency Out-of-Network Care. Generally, when a Medicaid Managed Care or a regular FHP enrollee uses out-of-network providers for inpatient care or emergency care services, public insurance plans pay the Medicaid reimbursement rate as a "default" rate for their services. However, the State's actuaries determined that the EBI program was a "commercial" product for out-of-network services. Adopting the Medicaid default rate would result in approximately a 1 percent premium reduction.[27] The Coalition of New York State Public Health Plans is a strong proponent of this measure.[28] While the premium reduction is small, adopting the Medicaid default rate would further support the argument that the EBI pro-

TABLE 6
New York State Fees and Surcharges

	Medicaid Fee-for-Service	Medicaid Managed Care/FHP	Child Health Plus	FHP EBI	Healthy NY	Direct Pay
HCRA Surcharge[22]		✔	✔	✔	✔	✔
Covered Lives Assessment[23]			✔	✔	✔	✔
Insurance Department Assessment (§332)[24] Applicable to licensed insurance companies				✔	✔	✔
Premium Tax Applicable to for-profit insurers[25]		Yes, if plan is for-profit	Yes, if plan is for-profit	SDOH has not noted this, but if the plan is for-profit, it should be subject to this tax.	Yes, if plan is for-profit	Yes, if plan is for-profit

gram is a public product and therefore not subject to private taxes and assessments and support the adoption of public provider reimbursement rates.

Adopt an Anti-Crowd-Out Rule to Further Support Reimbursng Providers at Public or Hybrid Rates. When Mercer established premium rates for the EBI program, it was assumed that providers would be paid at commercial reimbursement rates. This decision was informed by a desire within the Department of Health to ensure that providers were not financially harmed from potential cross migration of their patients from commercial insurance—which typically pays higher provider reimbursement rates—to the EBI program.

Targeting the program specifically to the uninsured would eliminate this concern, enabling plans to negotiate reimbursement rates at or near Medicaid levels, and significantly reduce premiums. Providers presumably would rather have a discounted-fee-paying patient over a no-fee-paying (uninsured) patient. Academic literature indicates that premiums may also drop further due to a lack of excessive pent up demand in the uninsured, and because their health status is better or the same as their insured counterparts.[29]

There is strong precedent for the adoption of public reimbursement rates for hybrid public/private insurance programs. In New York, the Fidelis/1199-SEIU pilot program was assumed to be a public program and utilized public insurance reimbursement rates for its providers. Similarly, New York's Child Health Plus (CHP) program either uses Medicaid reimbursement rates or hybrid reimbursement rates that are higher than Medicaid, but lower than commercial reimbursement.[30]

Nationally, a number of other states have adopted public or hybrid reimbursement rates for similar programs. CSS conducted an in-depth review of seven other hybrid programs operating around the country and determined that four of these states use Medicaid or less-than-commercial reimbursement rates with their providers.[31] Under its recently enacted health reform plan, Massachusetts also opted to limit its Commonwealth Care program to its existing public insurance plans, which use Medicaid-like rates. By using public insurance plans, the program was able to achieve premium rates that were 25 percent lower than its commercial counterparts.

New York State could specifically target the EBI program to uninsured workers by adopting an anti-crowd-out rule, which would bar enrollment to employer groups that had coverage in the period immediately prior to enrollment into the EBI program.[32] This rule would deter employers currently offering private coverage from dropping it. To address the legitimate fear that small businesses are rapidly being priced out of the small group market, the State could adopt a six-month waiting period for all employers and unions entering the EBI program, except small businesses and other entities with less than 50 employees that spend more than 15 percent of their payroll on health insurance.

TABLE 7
Premium Reduction from Adopting Public Program Rules for Taxes/Assessments

Surcharge	Actual Fee	Current Charge	Proposed Charge	Premium Reduction	Notes
HCRA Surcharge	Commercial 9.63% charge on hospital claims, Medicaid 7.04% charge on hospital claims	4.80%	3.50%	-1.30%	Assuming 50% of medical cost is hospital
CLA–	2009 NYC individual surcharge is annual $185.93 (Mercer)	2.90%	0.00%	-2.90%	Assuming covered lives assessment not applicable to FHP EBI
Insurance Department Assessment	0.90% of premium	0.90%	0.00%	-0.90%	Assuming insurance department assessment not applicable to FHP EBI
Premium Tax	1.75% of premium	1.75%	1.75%	0.00%	
Total Surcharges		**10.30%**	**5.27%**	**-5.10%**	

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.

The adoption of public insurance program rules for fees, taxes, and reimbursement rates will cumulatively generate a 36 percent premium reduction.

Step Three: Access the Healthy NY Stop-Loss pool
New York State currently spends $161 million in reinsurance funds to subsidize the low-benefit Healthy NY (HNY) program. Consumer advocacy groups have long questioned the value of HNY as a public means for supporting access to comprehensive affordable care. First, HNY subsidies are not targeted to low- or moderate-waged workers. Only 30 percent of employees must earn wages less than 370 percent of FPL (or $40,000 for an individual). And only one of those employees who earns $40,000 or less must enroll for an employer group to qualify; the remaining employees can have any income so long as 50 percent of eligible employees enroll.

Second, HNY has a limited benefit package with an actuarial value of roughly 77 percent. Advocates for people with chronic illnesses and disabilities argue that the HNY funding stream should be reallocated to fund comprehensive insurance that better meets the State's objectives to reduce the number of uninsured and offer quality coverage.[33]

Finally, under new federal health reform rules, HNY may not be considered a qualified health plan and, accordingly, will either have to be eliminated or modified extensively by State lawmakers in advance of 2014.[34] State policy makers should consider transitioning the employer-sponsored portion of the HNY stop-loss pool to support the EBI program (HNY enrollees associated with this funding could transition into the EBI program or other forms of coverage). This measure would reduce premiums by roughly 30 percent (depending on enrollment).[35]

Results

The cumulative result of adopting the three steps described above is a premium reduction of as much as 55 percent. If adopted, the final individual premium rate for the EBI program would be $242 per month (see Table 8).

By reducing the individual premium rate to $242, the employer's share drops from $378 under the original premium cost to just $169. The employee's share drops from $162 per month to just $72—only 8 percent of gross family income for childless enrollees earning just above 100 percent of FPL, and about 4 percent for parents earning just above 150 percent of FPL (see Table 9).

TABLE 8
Total Potential Premium Reduction

	Rate Reduction	
	($)	%
NYC Individual Small Group Policy Rate	**$541**	
Plan Design Adjustment (9%)	($49)	-9%
Tax/Assessment Adjustment (5.1%)	($27)	-5%
MA Default Rates for ER/OON Adjustment (1%)	($5)	-1%
Provider Reimbursement Adjustment (25%)	($115)	-21%
Healthy NY Stop-Loss Adjustment (30%)	($104)	-19%
Final Rate	**$242**	
Cumulative Reduction	($299)	-55%

Source: Gorman Actuarial Analysis for the Community Service Society of New York, 2010.
Note: Numbers may not sum due to rounding.

TABLE 9
Employer, Employee, and State Premiums, Post all Three Reductions

	Income Level	Individual Policy Rate	Employer Contribution	Employee Contribution	State Subsidy
Employee 1 (FHP-Eligible Childless Adult)	<100% FPL	$242	$169	$0	$72
Employee 2 (FHP-Eligible Parent)	<150%FPL	$242	$169	$0	$72
Employee 3 (Not FHP-Eligible Employee)	>100/150% FPL	$242	$169	$72	$0

Note: Numbers may not sum due to rounding.

Even without accessing the HNY stop-loss pool, premiums would be reduced by 36 percent by following the first two steps described above—adjusting the plan design and targeting the program to the uninsured. This reduction would result in a premium of $345—a significant improvement for employers and non-subsidized employees alike. Employees who are parents earning just above 150 percent of FPL would be required to pay no more than 5.6 percent of their gross annual income. Childless enrollees earning just above 100 percent of FPL would be required to pay about 11 percent of their gross annual income for coverage (see Table 10).

By leverging federal health reform's small business tax credit and adopting just the first two steps proposed here, the employer's portion of a monthly individual EBI health premium would be reduced to just $157 per month—a price unmatched in the existing insurance marketplace.

Conclusion

In the wake of the passage of federal health reform, the Family Health Plus Employer Buy-In program presents an important opportunity for New York policy makers for three reasons.

First, full implementation of federal reform will not occur until 2014. The EBI program, by contrast, is shovel-ready. More than 40,000 New Yorkers are already enrolled in the EBI under the Fidelis/1199-SEIU program—making it one of the largest hybrid employer/public programs in the country. Nearly two dozen health plans are familiar with the product's benefit design—they have existing networks of providers and marketing representatives. However, the EBI program, while comprehensive, is currently not affordable. If the program was modified to generate the significant premium reductions described above, it could potentially serve thousands of low- and moderate-waged workers.

Second, a key component of federal health reform—small business tax credits—begins this year (2010). The combination of the premium reductions described in this Policy Brief and the small business tax credits (of up to 35 percent of the cost of coverage) could further reduce EBI premiums for a number of workplaces.[36] Assuming the first two steps are achieved immediately, the individual premium per month could be reduced from the current $541 to $345 per month. Of this $345 premium, $242 would be paid by the employer and $104 by the employee or subsidized by the State. With the 35 percent small business tax credit, the employer's portion of a monthly individual premium would be reduced to

TABLE 10
Employer, Employee, and State Premiums, Post Reductions One and Two—Without HNY

	Income Level	Individual* Policy Rate	Employer Contribution	Employee Contribution	State Subsidy
Employee 1 Childless Adult	<100% FPL	$345	$242	$0	$104
Employee 2 Parent	<150%FPL	$345	$242	$0	$104
Employee 3	>100/150% FPL	$345	$242	$104	$0

Note: Numbers may not sum due to rounding.
*Healthy NY stop-loss pool offset not reflected in this rate.

just $157 per month—a price unmatched in the existing insurance marketplace. The employee's share would be around $104 per month.

Finally, even after the full implementation of federal health reform in 2014, including the individual mandate, employer penalties, and the establishment of state-based Exchanges, insurance premiums will remain unaffordable for many low-waged working families. As Table 11 demonstrates, a typical low-waged working family of three earning $36,000 per year will be asked to spend as much as 18 percent of its family income on health care costs. By contrast, New York's EBI program offers much lower cost-sharing.

The Employer Buy-In program was created to offer an alternative pathway to health insurance coverage for working New Yorkers. To date, an inherent conflict between two goals—(1) to cover the uninsured and (2) to provide employers an alternative to existing commercial products—has prevented the program from advancing either goal. By refocusing the EBI program on the uninsured and those working for small businesses at risk of dropping coverage, and adjusting its programmatic features to align with this explicit goal, the EBI can provide New Yorkers with an affordable option for extending comprehensive employer-based health insurance now and for years to come.

TABLE 11
Comparison of Affordability of Insurance in Federal Health Reform versus FHP EBI

Income		Maximum potential health care costs (as a % of income)*	
FPL	Income (family of 3)	PPACA	FHP EBI
150%	$27,465	18%	0%
200%	$36,620	18%	13%
250%	$45,775	19%	10%
300%	$54,930	22%	9%

* PPACA costs assume "silver plan" premium level and maximum out-of-pocket caps are achieved; FHP EBI costs assume premium and maximum $2000 in cost-sharing for employees is achieved.[37]

Appendix I: Summary Chart of Selected Hybrid Programs

Program Name	Program description	Comprehensive benefits?	Premiums/co-pays	Provider reimbursement rate	Total enrolled
New York: Child Health Plus (est. 1990)	Buy-in program for children above Medicaid eligibility levels, with subsidies up to 400% FPL.	Yes.	State subsidy is offered on a sliding scale based on FPL: • <160%: 0% • 160-222%: $9 • 223-250%: $15 • 251-300%: $30 • 301-350%: $45 • 351-400%: $60 • >400%: $130	Hybrid	400,000
Washington: Basic Health Plan (est. 1993)	Premium subsidy program for individuals up to 200% FPL.	Yes.	Monthly premiums are based on age, income, family size, and health plan chosen. Subsidies are offered on a sliding scale based on FPL: • <65%: $0 • 66-100%: $34 • 101-125%: $45 • 126-139%: $60 • 140-155%: $60 - $155 • 156-170%: $60 - $194 • 171-185%: $61 - $237 • 186-200%: $72 - $343	Commercial	66,000 (100,000 more on wait list)

Appendix I (cont.):
Summary Chart of Selected Hybrid Programs

Program Name	Program description	Comprehensive benefits?	Premiums/co-pays	Provider reim-bursement rate	Total enrolled
New Mexico: State Coverage Insurance (est. 2005)	Premium subsidy program for low-income uninsured and small businesses.	Yes.	Sliding scale based on FPL: • 0-100%: $0 • 101-150%: $95 (Employer $75/Employee $20) • 151-200%: $110 (Employer $75/Employee $35)	Medicaid	32,780 (10,000 more on wait list)
Oklahoma: Insure Oklahoma (est. 2004)	Premium assistance for low-income working or temporarily unemployed adults.	Yes.	ESI: employer pays at least 25%, em-ployee pays up to 15%, state pays rest. Individual plan: sliding scale by FPL: • 0-25%: $0 • 26-50%: $8.50 • 51-100%: $16.50 • 101-150%: $33 • 151-200%: $49	Medicaid (individual)	15,505
Vermont: Catamount Health (est. 2007)	State-sponsored private health plan for uninsured adults with-out access to ESI, and premium assistance for individuals with ESI below 300% of FPL.	Yes.	For state program, premiums based on a sliding scale based on FPL: • <200%: $60 • 200-225%: $90 • 226-250%: $110 • 251-275%: $125 • 276-300%: $135 For the ESI program, the employer pays standard amount, employee pays based on above scale, and state pays the rest.	Medicare	9,740
Oregon: Family Health Insurance Assistance Program (est. 2002)	Premium assistance for low-income adults without access to ESI.	Yes.	State subsidy is offered on sliding scale based on FPL: • <125%: 95% of premium covered • 126-150%: 90% covered • 151-170%: 70% covered • 171-185%: 50% covered	Commercial	6,532 (60,000 more on wait list)
Arkansas: ARHealthNet (est. 2006)	Buy-in program for small to medium businesses, with pre-mium subsidies for low-income employees.	No.	For employees: • <200% FPL: $25/mo. • >200% FPL: $250/mo. *Employer levels are unavailable. • 15% flat co-pay on all services except pharmacy. • $100 annual deductible. • $1,000 per year out-of-pocket max. for co-pays and deductibles.	Commercial	4,696
Michigan: Access Health (est. 1999)	Regional ESI program for moderate-income working adults.	Yes.	Employer and employee each contribute 30% to the premium and the community contributes 40% (largely through DSH funds). Total premium is $148/mo. for adults, $95/mo. for kids.	Hybrid	1,200

Appendix II

In 2009, the New York State Department of Health hired the Mercer actuarial firm to develop the premium rates for the EBI program. That same year, Mercer made a series of public presentations about their premium results. Initially, a number of stakeholders expressed concern about Mercer's decision to use a New York City preferred provider organization (PPO) product as the basis for developing the EBI premiums. At CSS's request, Gorman Actuarial (GA) reviewed Mercer's rate development methodology for the EBI program and re-built the EBI premiums using a more diverse claims base and by varying some of Mercer's underlying assumptions. Specifically, GA:

1. Started with commercial small group claims per member per month for calendar year 2006;
2. Increased costs for trend by 8 percent annually for 4 years;
3. Decreased costs by 2.3 percent for difference in region distribution;
4. Increased costs by 12 percent for difference in plan design, and;
5. Added an administrative PMPM charge of $36.55 and increased overall rates by 2 percent to account for profits.

The Claims Base

Mercer used the claims experience for a large employer enrolled in a PPO product as the basis for their premium rate development, and then adjusted this claims base to reflect a health maintenance organization (HMO) product. GA instead utilized claims data from the New York HMO Small Group Market as a starting point by reviewing New York State Department of Insurance loss-ratio filings (Section 4308(h)) for calendar year 2006. This data included complete HMO small employer group data for CDPHP, Excellus, HIP, and Oxford, and represented approximately 350,000 members. Claims include an adjustment for those incurred but not reported (IBNR). See Table A.

TABLE A
New York Small Group Market Claims Base

CY 2006	MM	Claims PMPM	Revenue PMPM	MLR
CDPHP	466,000	$198	$240	.83
Excellus	1,069,000	$222	$243	.91
HIP	461,000	$252	$317	.79
Oxford Health Plans	2,199,000	$293	$385	.76
Total	**4,194,000**	**$260**	**$325**	**.80**

Note: Numbers may not sum due to rounding.

Adjustment Assumptions

a. **Trend assumption:** GA analyzed claims trends for the small group market over time by reviewing NY HMO annual filings from calendar years 2000 to 2006 and found the average annual trend to be 8 percent.
b. **Regional adjustment:** GA reviewed the Section 4308 filings in order to determine the commercial distribution for the CDPHP, Excellus, HIP, and Oxford plans. GA also reviewed the current FHP distribution. The cumulative data was summarized into the FHP regions.

Assuming that the FHP employer group distribution by region will resemble the current FHP distribution, GA calculated a composite Mercer Rate of $519. Area factors were calculated using the composite rate of $519 and the Mercer rates. GA assumed that the Mercer's regional adjustments appropriately reflected the underlying cost structures.

TABLE B
Imputed Area Factors by Region

Region	EBI Small Group	FHP Distribution	Area Factors
Central	$423	3%	0.81
Finger Lakes	$444	3%	0.86
Long Island	$523	6%	1.01
Mid-Hudson	$525	2%	1.01
New York City	$541	70%	1.04
Northeast	$429	3%	0.83
Northern Metro	$534	3%	1.03
Utica-Adirondack	$412	3%	0.79
Western	$434	6%	0.84
Total	**$519**		

TABLE C
Tier Distribution & Family Size

	Rate Ratios	Distribution	Average Family Size
Individual	1.00	70%	1.0
Dual	2.01	8%	2.0
EC	1.85	8%	2.5
Family	2.95	15%	4.0

c. **Plan design adjustment:** GA examined the benefits for the EBI plan design and assessed it to have an actuarial value of 98 percent. This actuarial value was found to be 12 percent higher than products on the existing small group market. See Table 1 (main report).

d. **Administration and profit assumptions:** The per member per month administrative costs for the FHP program was $34. GA assumed that the administrative cost would increase 7 percent to project to calendar year 2010. A 2 percent profit margin was also assumed.

e. **Tier distribution and family size:** GA developed rate ratios by reviewing Mercer's rates and a tier distribution assumption was produced by reviewing the existing New York State claims data and publicly available data on the Massachusetts small group market. The average family size assumption was also developed based on the Massachusetts small group market. See Table C.

Gorman Actuarial's Rate Build-Out

GA's calculated small-group rate was roughly 4–5 percent lower than Mercer's rate. However, this rate did not include the HCRA surcharges and Insurance Department taxes which, as described above, would add an additional 5 percent to the rate set forth below. Also, the rate did not reflect differences between the uninsured population and commercial enrollees. Healthy NY enrollment and FHP provider contracts were also excluded.

Accordingly, GA's rates do not significantly vary from those established by Mercer for the New York State Department of Health. See Table D.

TABLE D
Final Rates

I. Mercer's Rates - Small Group, Effective 1/1/10				
	Individual	2 Adults	Parent + Child(ren)	Family
Central	$423	$850	$780	$1,243
Finger Lakes	$444	$895	$821	$1,307
Long Island	$523	$1,051	$965	$1,537
Mid-Hudson	$525	$1,053	$966	$1,542
New York City	$541	$1,101	$1,014	$1,594
Northeast	$429	$861	$790	$1,260
Northern Metro	$534	$1,072	$984	$1,571
Utica-Adirondack	$412	$826	$757	$1,212
Western	$434	$874	$803	$1,276

II. Gorman Actuarial Estimates			
Individual	2 Adults	Parent + Child(ren)	Family
$403	$811	$746	$1,186
$424	$853	$785	$1,247
$499	$1,003	$923	$1,467
$501	$1,007	$927	$1,472
$516	$1,037	$955	$1,518
$409	$822	$757	$1,203
$510	$1,025	$944	$1,500
$394	$791	$728	$1,158
$414	$832	$766	$1,217

III. Percent Difference			
Individual	2 Adults	Parent + Child(ren)	Family
-4.5%	-4.6%	-4.4%	-4.6%
-4.5%	-4.7%	-4.5%	-4.6%
-4.5%	-4.6%	-4.4%	-4.6%
-4.5%	-4.4%	-4.1%	-4.5%
-4.5%	-5.8%	-5.8%	-4.8%
-4.5%	-4.5%	-4.2%	-4.5%
-4.5%	-4.4%	-4.1%	-4.5%
-4.5%	-4.2%	-3.8%	-4.5%
-4.5%	-4.8%	-4.7%	-4.6%

Appendix III

Interviews for this report were provided by the following individuals:

John Arensmeyer, Founder and CEO, Small Business Majority
Judy Arnold, Director, Division of Coverage and Enrollment, NYS Dept. of Health
Deborah Bachrach, Visiting Fellow, New York State Health Foundation
Mitra Behroozi, Executive Director, 1199-SEIU Benefit and Pension Funds
Michael Birnbaum, Director, The Medicaid Institute, United Hospital Fund
Maura Bluestone, President, Affinity Health Plan
Patricia Boozang, Consultant, Manatt, Phelps & Phillips, LLP
Senator Neil Breslin, Chair, NYS Senate Insurance Cmte.
Kim Browning, Vice President of Safety Net Division, Excellus
Courtney Burke, Director, New York State Health Policy Research Center, The Rockefeller Institute of Government
Jim Burnosky, Assistant Vice President of Strategic Planning and Development for Fidelis Care
Ishmael Carter, Vice President of Marketing, and Hannah Erickson, Marketing Analyst, Neighborhood Health Plan
Bob Cohen, Policy Director, Citizen Action of New York, Public Policy and Education Fund
Richard Conti, Executive Director, NYS Assembly Health Cmte.
Maureen Cozine, Communications Director, New York State Health Foundation
Trilby deJung, Senior Staff Attorney, Empire Justice Center
Susan Dooha, Executive Director, Center for the Independence of the Disabled of New York
Senator Thomas Duane, Chair, NYS Senate Insurance Cmte.
Melinda Dutton, Partner, Healthcare Industry, Manatt, Phelps & Phillips, LLP
Tom Early, Executive Director, David Willhoft, Director of Marketing and Business Development, and Nick Liguori, Director of Strategic Planning, Health Plus
Kevin Finnegan, Political Director, 1199-SEIU
Anthony Fiore, Senior Manager, Manatt, Phelps & Phillips, LLP
Rev. Patrick Frawley, Executive Vice President and COO, Fidelis Care
Donna Frescatore, Medicaid Director, Deputy Commissioner, Office of Health Insurance Programs, NYS Dept. of Health
Benjamin Geyerhahn, New York Director, Small Business Majority
Jeffrey Gold, Vice President and Special Counsel, Managed Care, Healthcare Association of New York
Lou Gordon, Director, Business and Labor Coalition of NY
Bela Gorman, Lead Consultant, Gorman Actuarial, LLC
Richard Gottfried, Chair, NYS Assembly Health Cmte.
Elizabeth Hamlin, Legislative Associate, Office of Assemblymember Richard Gottfried
Mark Hannay, Executive Director, Metro New York Health Care for All
Harold Iselin, Counsel for the New York Health Plan Association, Greenberg Traurig, LLP
Craig Johnson, Chair, NYS Senate Cmte. on Investigations & Government Operations
Lara Kassel, Coordinator, Medicaid Matters New York, Center for Disability Rights
Michael Kink, Director of Counsel and Program, NYS Senate
James Knickman, President and CEO, New York State Health Foundation
Senator Liz Krueger, Chair, NYS Budget and Tax Reform Cmte.
Mark Lane, President and CEO, Fidelis Care
Amy Lee, Program Asst., New York State Health Foundation
Vallencia Lloyd, Deputy Director, Division of Managed Care, NYS Dept. of Health
Sheila Nelson, Vice President, Public Policy & Regulatory Affairs, New York Health Plan Association
Troy Oechsner, Deputy Superintendent for Health, NYS Dept. of Insurance
Theo J. Oshiro, Director of Health Advocacy, Make the Road New York
Bryan O'Malley, Deputy Team Leader/Health Analyst, NYS Senate
Regina Perez, Senior Vice President, Marketing & Provider Network Management, Neighborhood Health Plan
Kate Powers, Counsel to Senate Insurance Cmte., Office of Senator Neil Breslin
Jenny Rejeske, Health Advocacy Coordinator, New York Immigration Coalition
David Sandman, Senior Vice President, New York State Health Foundation
Wendy Saunders, Deputy Secretary for Health, Medicaid and Oversight, Office of Governor David A. Paterson
Lisa Sbrana, Supervising Attorney, Health Law Unit, The Legal Aid Society
Mark Scherzer, Legislative Counsel, New Yorkers for Accessible Health Coverage
Melissa Seeley, Program Officer, New York State Health Foundation
Kinda Serafi, Director of Policy, Children's Defense Fund (NY)
Kathleen Shure, Senior Vice President, Managed Care and Insurance Expansion, Greater New York Hospital Association
Heidi Siegfried, Director of Health Policy, New Yorkers for Accessible Health Coverage/CIDNY
Denise Soffel, Executive Director, Senate Health Committee, Office of Senator Thomas Duane
P.J. Weiner, Manager of Advocacy Program, National Multiple Sclerosis Society (NYC-Southern New York Chapter)
Dennis Whalen, Executive Vice President, Healthcare Association of New York State
Emily Whalen, Associate Counsel/Analyst for Insurance, Banks and Consumer Protection, NYS Senate Majority Conference
Cathy Weigle, Vice President of Business Development (via phone)—Neighborhood Health Plan

Notes

1. CSS's annual poll of New York City residents, "The Unheard Third," has found a decline in the number of low-income workers who report receiving health insurance from their employer over the past seven years. CSS "The Unheard Third Survey, 2002-2009," available at www.cssny.org. *See also* 2009 New York Health Benefits Survey, conducted by NORC and published by NYS Health Foundation, forthcoming.
2. CSS's review of state programs found that the majority of hybrid programs are premium assistance programs for employees (27 premium assistance programs were identified). Approximately eight states ran basic health plans or buy-in programs geared towards employers.
3. N.Y. Soc. Servs. Law §369-ff.
4. Insurance premium increase data from U.S. Department of Health and Human Services, "The Health Care Status Quo: Why New York Needs Health Reform," available at http://www.healthreform.gov/reports/statehealthreform/newyork.html, n. 3, citing The Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1. Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D. Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at: http://www.cms.hhs.gov/nationalhealthexpenddata (viewed November 2009).
5. Families USA, "Costly Coverage: Premiums Outpace Paychecks in New York," September 2009.
6. New York State Insurance Department, "The Price of Deregulation: How 'File and Use' Has Undermined New York State's Ability to Protect Consumers from Excessive Health Insurance Premiums," June 2009.
7. E. Anderson, "Healthy Rise Hits Insurance Costs," *Albany Times Union*, March 17, 2010.
8. CSS, "Cornerstone for Coverage," November 2009.
9. Workers include persons aged 19-64 who work full- or part-time, including self-employed workers. Dependents include non-working spouses, children aged 0-18, and full-time students aged 19-22. United Hospital Fund, "Health Insurance Coverage in New York, 2006-2007," June 2009
10. United Hospital Fund, "Health Insurance Coverage in New York, 2006-2007," June 2009.
11. Small Business Majority, "The Economic Impact of Healthcare Reform on New York's Small Businesses," November 2009.
12. UHF, *supra,* n. 9.
13. New York State Department of Health, Monthly Medicaid Managed Care Enrollment Report, May 2010.
14. N.Y. Soc. Servs. Law §369-ff(1)(c).
15. Gorman Actuarial analysis prepared for CSS based upon data provided by the New York State Department of Insurance.
16. Comments of Mark Lane, CEO, Fidelis Health Plan, and Mitra Behroozi, Executive Director, 1199-SEIU Benefit and Pension Funds, at NYS Health Foundation Meeting, January 22, 2010.
17. *See, e.g.*, Letter from Roger B. Adler, Counsel, New York State Senate Committee on Investigations and Government Operations to Mr. James Clancy, Assistant Commissioner, Government External Affairs, New York State Department of Health, (noting that the State's EBI rates "puzzlingly high" when compared to those used for the 1199-SEIU pilot and opening a "'preliminary inquiry'" on the matter), October 2, 2009.
18. Interview with Benjamin Geyerhahn, Small Business Majority Foundation, (noting that the EBI program has non-competitive premiums and additional administrative burdens compared to commercial products already available in the market), April 6, 2010.
19. Interview with Jim Burnosky, Assistant Vice President of Strategic Planning and Development for Fidelis Care, October 19, 2009. The Fidelis pilot program for the 1199/SEIU population is not currently subject to either the §332 assessment or the covered lives assessment.
20. Gorman Actuarial analysis prepared for CSS.
21. 2010-11 NYS Executive Budget, Department of Health and Mental Hygiene, Article VII legislation, Part B, §37. Available at: http://publications.budget.state.ny.us/eBudget1011/fy1011artVIIbills/HMH_ArticleVII.pdf.
22. N.Y. Pub. Health Law §2807-j.
23. N.Y. Pub. Health Law §2807-s (CLA, if payor elects to pay regional surcharge, which almost none do); New York State Public Health Law §2807-t (CLA, if payor elects to pay monthly assessment, which essentially all do).
24. N.Y. Ins. Law §332.
25. N.Y. Tax Law §1502-a.
26. Gorman Actuarial analysis prepared for CSS.
27. Gorman Actuarial analysis prepared for CSS.
28. Coalition of New York State Public Health Plans, "Memorandum of Support for Changes to the Family Health Plus Employer Buy-in Program," 2010.
29. *See, e.g.*, L. Ward, P. Franks, "Changes in Health Care Expenditure Associated with Gaining or Losing Health Insurance," *Annals of Internal Medicine*, Vol. 146, No. 11 at 768, June 2007; H. Boagrad, D. P. Ritzwoller, N. Calonge, K. Shields, M. Hanrahan, "Extending Health Maintenance Organization Insurance to the Uninsured: A Controlled Measure of Health Care Utilization," *Journal of the American Medical Association*, Vol. 277, No. 13 at 1067, April 2, 1997; S. Long, M.S. Marquis, J. Rodgers, "Do People Shift their Use of Health Services Over Time to Take Advantage of Insurance," *Journal of Health Economics*, Vol. 17, 105-115 (1998).
30. CHP premium rates are negotiated between participating CHP insurance plans and the State Department of Insurance. Public Health Plans (PHPs) tend to use Medicaid reimbursement rates for their providers whereas commercial plans tend to use commercial rates. (Interview with T. Fiori, counsel to New York Association of Public Health Plans, 2009.)
31. CSS reviewed hybrid programs in Arkansas, Michigan, New Mexico, Oklahoma, Oregon, Vermont, and Washington. We found that Michigan, Vermont, Oklahoma, and New Mexico used provider reimbursement rates that were lower than commercial rates.
32. The State's Healthy NY program has a strict anti-crowd-out rule which bars an employer's participation in Healthy NY if it has offered coverage within the prior 12 months. N.Y. Ins. Law §4326(3)(c)(1)(A)(i).
33. Interview with Mark Scherzer, Legislative Counsel, New Yorkers for Accessible Health Coverage, 2010.
34. The Patient Protection and Accountable Coverage Act ("PPACA") states that a "qualified plan" must include the "essential health benefits package." The Patient Protection and Accountable Coverage Act of 2010 Public Law 111-148, §1301. Section §1302 of PPACA includes mental health, substance abuse disorder service, and pediatric oral and vision care – benefits which are excluded from the Healthy NY benefit package. In addition, PPACA states that rehabilitative and habilitative services and devices must be included in the benefit package. While Healthy NY does offer physical therapy and home health care, durable medical equipment is excluded from its benefit package. *See* Healthy NY benefit package, located at: http://www.ins.state.ny.us/website2/hny/english/hnybp.pdf
35. Gorman Actuarial analysis prepared for CSS.
36. Between 2010-2013, tax credits will be available for small businesses with fewer than 25 full-time equivalent employees earning average wages of less than $50,000 and which contribute at least 50% of the total insurance premiums. Credit amounts will phase in based on the number of employees and average earnings, with the maximum tax credit of 35% available to businesses with fewer than 10 employees, earning less than $25,000 in annual wages. Nonprofit organizations are eligible for tax credits (off of Medicare taxes) of up to 25% of the employer contribution. An enhanced version of the credit will be available in 2014. PPACA, *supra,* n. 34 at §1421.
37. Under PPACA, the "silver level" plans will have higher actuarial values for people below 250% (94% for people below 150% of FPL; 87% for people between 150-200% of FPL; and 73% for people between 200-250% of FPL) than for those at above 250% of FPL (when the "silver level" plan will have an actuarial value of 70%). PPACA, *supra,* n. 34 at §1402 (c)(2). However, the maximum cost-sharing analysis displayed in this table is unaffected by these higher actuarial values.

Community Service Society

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