



July 18, 2008

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Re: Community Service Society
Comments on Partnership for Coverage
Draft Modeling Instructions for the Urban Institute

Dear Deputy Commissioner Bachrach and Deputy Superintendent Oechsner:

Thank you for the opportunity to comment on the Partnership for Coverage draft Urban Institute Modeling Options documents. The Community Service Society (CSS) contributed to the submission on behalf of the Health Care for All New York (HCFANY), which provides a comprehensive overview of our feedback on the modeling proposal. As mentioned in the HCFANY comments, CSS is particularly gratified to see that the State has requested the Urban Institute to model the CSS affordability schedule in the public/private reform proposal.

In this the letter we write to present additional information on two issues of particular import to CSS that we believe should help inform the modeling process: (1) immigrant coverage and Emergency Medicaid, and (2) affordability. Over the course of the past year, CSS has undertaken an in depth examination of both of these issues. We have included a sampling of our work here and hope that you will find the information

provided to be useful. Should you have any questions regarding the Community Service Society's *Cornerstone for Coverage* Proposal, I have attached a copy of our project scope and methodology memo,

which outlines the details of our proposal. We would also welcome the opportunity to meet with you in order to discuss this information in further detail.

I. Immigrant Coverage

We are pleased to see that the inclusion of all state residents – including immigrants – will be modeled in all proposals. One of the challenges in modeling immigrant coverage in New York is distinguishing different types of immigrants. As you know, New York State provides coverage under public health insurance for immigrants who are excluded from federal Medicaid and SCHIP programs.¹ National health researchers have traditionally clumped immigrant status categories together to generate an estimated number of “unauthorized” residents.²

However, this approach will lead to serious modeling flaws in New York, given that subgroups within the “unauthorized” category currently are eligible for and receiving public coverage. To prevent inflating the cost of a health reform proposal, the modeling must adjust for immigrants who are considered PRUCOL for Medicaid/SCHIP purposes, the absence of the five year bar our state health coverage programs, and the significant in–migration of foreign born individuals with a range of immigration statuses each year.

In the course of developing our *Cornerstone for Coverage* proposal, CSS relied on the work of Jeffrey Passel and his colleagues to develop an estimate of the number, demographics, and level of uninsurance among PRUCOL and other “non-federally qualified” immigrants for public insurance purposes and the potential savings attributed to an anticipated reduction in the use of Emergency Medicaid. We believe that our resulting estimate may be of use to you in the modeling process, and are happy to discuss our findings and share our methodology.

II. Affordability

¹ New York State's highest Court has held that all lawful immigrants—including those who are in the process of adjusting their status or are permanently residing under color of law (PRUCOL)—cannot be precluded from public health coverage solely due to their immigrant status. *See Aliessa v. Novello*, 96 N.Y.2d 418, 730 N.Y.S.2d 1 (2001).

² Most researchers find that “unauthorized immigrants” include categories of immigrants without permanent resident status and who are Permanently Residing Under Color of Law (“PRUCOL”). *See, e.g.* Passel, J. [Unauthorized Migrants: Numbers and Characteristics](#), Pew Hispanic Center, June 14, 2005; Passel J. [The Size and Characteristics of the Unauthorized Migrant population in the U.S. estimates Based on the march 2005 current Population Survey](#), March, 2006

In the context of public programs, there is by definition a trade-off between the cost to beneficiaries and the cost to government. In Massachusetts, the healthcare reform program was designed and modeled with project affordability (limiting the government cost of the program) as a starting point, rather than individual affordability for families. While a causal relationship between affordability and coverage is not fully established, a number of studies of the insurance market in general find that coverage is unaffordable for between 40% and 75% of the uninsured, with the variation due to different thresholds of affordability.³

At CSS, we believe that, while controlling government costs is vital, individual affordability is central to the success of any state health reform effort, especially as low- and moderate-income families have faced a 91% increase in premiums, compared to a 24% increase in wages, between 2000 and 2007.⁴ Accordingly, in the context of these rising healthcare costs and premiums, increased cost-sharing and cost-shifting in health insurance plans and growing medical debt and resulting bankruptcies, the issues of access to and affordability of health care is all the more urgent. As such, we believe that it is necessary to develop a program design (and associated modeling assumptions) which work from the point of individual affordability, rather than program affordability, to develop a program which will truly be accessible to all uninsured New Yorkers. Without reasonable affordability standards, state reforms may fail in their intention to provide relief or expanded access, and, in some contexts (as with health insurance mandates), may inflict harm on those they seek to help by imposing unattainable requirements on families' limited financial resources.

We applaud the State's decision to include the affordability assumptions outlined in the CSS *Cornerstone for Coverage* proposal. These affordability levels are in keeping with the needs and financial constraints of low- and moderate-income New Yorkers, and we appreciate that the State has recognized the need to model healthcare reform with a subsidy schedule built on the foundation of individual affordability. The cost sharing levels proposed in the *Cornerstone for Coverage* are derived from extensive research on affordability in New York conducted by CSS, some of which is described in summary form below.

One of the primary methodologies used to determine affordability is a behavioral model, observing what people are currently paying (or refusing to pay) for healthcare or

³ Bundorf, MK and Mark V. Pauly, "Is health insurance affordable for the uninsured?" *Journal of Health Economics*, Vol. 25. 2006. pp. 652. Extrapolated from several previous articles addressing housing affordability.

⁴ Schoen, C., Collins, S., Kriss, J. and Doty, M., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs*, web exclusive, 10 June 2008 at 1.

health insurance. Polling is also an important way to learn what New Yorkers are currently paying for healthcare and health insurance, as well as their opinions about what cost levels they would consider affordable or unaffordable. CSS has approached the question of affordability through: (1) an analysis of data from the Medical Expenditure Panel Survey (MEPS) on families with ESI, and (2) a Statewide telephone survey using the national pollster Lake Research Partners. Both analyses established that roughly 5% of family income is a reasonable affordability threshold for health coverage.

A. *MEPS Analysis*

CSS analyzed health costs and premiums of those New Yorkers who access health insurance through their employer, and employer-sponsored insurance in order to establish a reasonable universe within which to consider the affordability of healthcare and health insurance coverage. Our analysis of MEPS data on families receiving ESI insurance through a current employer in the Northeast Region found that 73% of families pay less than 7% of their gross family income on health care costs (premiums *and* out-of-pocket costs), and 61% pay less than 5%.⁵ Our MEPS analysis has previously been presented to the State, and we can provide more information to you upon request.

B. *Telephone Survey Data on Affordability in New York State*

While large datasets such as MEPS provide useful and important information about healthcare affordability, we felt that it was important to gather more detailed information directly from New Yorker families in different regions of the state.⁶ Working with Lake Research Partners, our telephone survey provided significant additional information on the specific affordability thresholds and concerns of New Yorkers.⁷ For example, our survey found that 34% of moderate income (200%-400% of the federal poverty level) New Yorkers who wanted but declined offers of employer sponsored insurance, did so because it was unaffordable.⁸

Generally, the polling results supported an affordability threshold of roughly 5% of family income. A majority (57%) of New Yorkers at every income level said that paying about 5% of their before-tax income on health care was about right; 27% of New Yorkers thought 5% was too much and only 9% of New Yorkers thought 5% was too little. Respondents with children were much more cost sensitive on this question, with 36% of parents saying that spending 5% of their pre-tax income was too much.

⁵ Data was drawn from the 2002, 2003 and 2004 MEPS-HC (Panel 6 Round 3, Panel 7 Round 1, Panel 8 Round 1 and Panel 9 Round 1) of individuals and families residing in the Northeast census region (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont), with costs and income trended forward to 2007.

⁶ Prior to conducting our large State-wide telephone survey, CSS also conducted a convenience sample in roughly 20 counties across New York State in order to gather qualitative information about health care affordability in New York State.

⁷ In November 2007, working with Lake Research Partners, CSS interviewed 1,619 New York State residents in four regions of New York: New York City, Long Island, Rural Upstate and Urban Upstate communities. The margins of error are +/- 2.5% for our statewide results and +/- 4.9% for our regional results.

⁸ Moderate income New Yorkers declined offers of employer sponsored income for the following reasons: 34% wanted it, but could not afford the insurance; 42% were already covered by other health insurance (such as a spouse), 4% stated it was not worth the cause; and 19% answered other or did not know the answer to the question. Similar findings were reported among New Yorkers below 200% of FPL. Polling data available from CSS upon request.

Support for these affordability thresholds is consistent among low-income (<200% FPL), moderate income (200-400% FPL) and at higher income (>400% FPL) New Yorkers.⁹ A majority of respondents at each income level supported the individual or family health insurance premiums that they would be asked to pay under the CSS *Cornerstone for Coverage* affordability schedule, with the exception of some skepticism of proposed family premiums at the highest income levels. Overall, the insured reported the ability to spend somewhat more on health care than those who were currently uninsured.

Polling also documented the extent to which the uninsured have no safety net in the event of a medical emergency. We found that 58% of New Yorkers below 200% of FPL have less than \$500 in savings, and 32% of those between 200%-400% of FPL have less than \$500. Of the uninsured, 63% had less than \$500 in savings, and fully 36% reported having no savings to fall back on at all (compared to 32% and 13% respectively for those with insurance).

Additional information from our polling is attached, and additional detail can be provided upon request.

In closing, we would once again like to thank you for the opportunity to share our comments. We hope that you have found the information we have shared to be useful. Again, we would very much welcome the opportunity to present and discuss this to you in further detail and depth. To set up a meeting with us, or if you have any further questions, please contact Elisabeth Benjamin at: (212) 614-5461.

Very truly yours,

Elisabeth Ryden Benjamin, MSPH, JD
Director, Healthcare Restructuring Initiatives

cc: Melinda Dutton, Partner, Manatt Health Solutions

⁹ There was a little more resistance to our proposed affordability thresholds amongst families above 400% of the FPL.