



July 21, 2008

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RE: Comments on Partnership for Coverage Modeling  
Instructions

Dear Ms. Bachrach and Mr. Oechsner:

The New York Health Plan Association (HPA) appreciates the opportunity to provide comments on the instructions provided to the Urban Institute for modeling four options to expand health insurance coverage for New Yorkers. We believe that health care reform decisions and directions should be guided by objective data and comprehensive analyses. If structured correctly, the modeling results will enable policy makers and health care stakeholders to determine the options that provide the most value in terms of individuals covered, quality of care, fiscal requirements and ability to contain rising health care costs.

I. General Comments

A. Cost Containment and Quality

The modeling instructions offer little information for the agencies or policy makers on the ability of each of the models to meaningfully address the cost of health care. We believe this is a potentially fatal flaw. In the absence of some analysis of cost containment, the modeling will produce a snapshot that indicates the cost of the different options as a starting point for moving forward. However, that will fail to address the cost of each option on a go-forward basis. This is critical information for policy-makers because whatever the

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price tag is at the outset, the future year cost is an even more important factor in determining which model should be the basis for reform.

We recognize the challenge in developing a cost containment methodology that captures the many variables related to this issue. Clearly, the methodology must address utilization, unit cost, new technology and behavioral and political factors that are difficult to quantify. However, there are studies that look at the relative rate of growth of different models of coverage and these could provide some basis for introducing cost containment into the modeling.

This also relates to factoring in quality. Simply providing coverage without ensuring better quality is an approach that produces little value to those who will be asked to pay the cost. The instructions should also model the ability of different systems to require quality and to foster innovation in the delivery of health care.

#### B. Benefit Package

With the exception of the Freedom Plan, each of the coverage options assumes the same benefit package, i.e., the Family Health Plus (FHPlus) package with full mental health parity. The instructions cite the following rationale, "This allows for effective comparisons of other variables across models." While holding this factor constant across various proposals may reduce the likelihood that variance in benefit package will confound the modeling results, this decision also presupposes that the FHPlus is the optimal package for analysis in each of the modeling options.

FHPlus, with the addition of full mental health parity, constitutes a comprehensive set of benefits. Selection of this package may make sense for the Single Payer and the New York Health Plus models. Holding the benefit package constant across these two models may yield interesting information related to other factors, such as the effect when the state pays providers versus the use of managed care plans to provide the coverage. However, its selection for the combined public-private model makes little sense given the menu of market reforms also included in this model.

In some cases, the instructions indicate that additional benefit packages may be examined in the future. HPA believes the lack of analysis of varying benefit packages will limit the utility of the resulting information. For example, the state will not learn the degree to which less rich benefit packages may allow the state to achieve price points that are attractive to the employers who do not provide coverage or to individuals — such as young adults — who often are uninsured.

## II. Specific Comments and Questions

### A. Combined Public-Private Proposal

HPA has long supported reform efforts that build upon the best elements of the public and private health insurance in New York. The economic realities facing the low to moderate income uninsured and employers who struggle to provide health coverage for their employees suggest that these groups and individuals might benefit from a two-pronged public/private approach. Such an approach would most likely entail simplification of and modest expansion of government sponsored programs in conjunction with significant and meaningful private market reforms to make the cost of coverage more affordable for individuals and employers.

The proposed combination option that is being modeled, however, appears to suffer from the “everything but the kitchen sink” approach. With respect to the proposed private market reforms in particular, it is unclear whether all of the items actually represent private market reform and whether each is to be considered an integral part of an overall, comprehensive market approach.

For example, the introduction of a public program buy-in, from an insurance policy perspective, appears to run counter to the goals of the other listed reforms – which are aimed at bolstering and making more affordable the coverage that people buy individually or obtain through employment. A buy-in program will, by design, remove individuals and groups previously covered under community rated products through employment. As we have discussed with the Departments of Insurance and Health previously, HPA is concerned that this approach could have serious consequences for the stability of the small group market and the affordability of employer-based coverage.

The remaining reforms to be modeled also appear to be incomplete in design. For example, the proposed merger of the individual and small group market is a market reform to model. It is our understanding that the proponents of merged markets believe such a merger would increase affordability because the merged pool would spread costs across businesses and individuals. However, the only product offering to be modeled for the proposed merged market is FHPlus. The limitation of modeling only FHPlus significantly undermines the prospects of this approach. The FHPlus benefit package, with full mental health parity and very limited cost sharing, well exceeds that offered by the typical small business as well as the state’s direct pay product. Thus, the key elements that are integral to the success of this reform approach are missing.

The description of modeling several of the other market reforms is unclear and potentially incomplete. The proposal appears to take into account adjustments to community rating, such as age bands, but the model declines to examine the

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introduction of a “young adult” product, for which the age bands would be necessary. In addition, the description addresses the possibility of expanding the definition of small group to 99 employees, yet the proposed exchange would offer products to groups up to 50 or to all groups. As mentioned previously, limiting the product offering by the exchange to only the FHPlus package appears to significantly constrain the evaluation. As with the market merger, an exchange is presupposed to offer multiple coverage options, thus an evaluation of an exchange offering only one seems to run counter to its intended purpose.

Finally, the description of the use of stop loss in the combination approach provides little detail. As you know, the HCRA stop loss funding for the direct pay product is insufficient. It is unclear how the stop loss corridors would be modeled and whether the model presumes full funding of all such claims. It is also unclear whether the stop loss modeling is for products in the merged individual and small group markets, or whether this approach is unrelated to the merger and will be evaluated separately. In addition, the model fails to consider the impact of other risk adjustment mechanisms, such as Regulation 146, on the cost of certain options. This regulation significantly increases small group costs and actually destabilizes the market because of its unpredictability. It is unclear how the modeling will address this issue.

B. The Freedom Plan

The Freedom Plan modeling also appears to have a substantial gap in the proposed analysis. In the area of HMO regulatory flexibility, the Urban Institute cites a lack of data with which to model the impact on affordability of products if HMOs are permitted to offer products with similar cost sharing as those offered by insurers. HPA is disappointed that this element of the modeling is missing, as we have recommended this reform approach for many years. It is unclear why data are lacking and we recommend the Urban Institute work with the Department of Insurance to explore how it may make data available to support this important analysis.

We look forward to continuing to work with the Departments of Health and Insurance on health care reform issues and appreciate the opportunity to provide input on your modeling initiative. Please contact me if you have any questions concerning our comments.

Sincerely,



Paul F. Macielak  
President & CEO