

NARROWING NEW YORK'S HEALTH INSURANCE COVERAGE GAP

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EXECUTIVE SUMMARY

Health insurance improves health, increases life expectancy, and bolsters economic security by reducing medical debt and bankruptcy. New York State has historically provided more coverage options than most other states, including broad eligibility for Medicaid and other public programs even before it fully implemented the Affordable Care Act (ACA). The ACA's benefit improvements, financial premium subsidies, and Basic Health Program option helped reduce New York's uninsured rate from 11.9 percent in 2010 to 5.2 percent in 2019.

Still, more than 1 million New Yorkers remained uninsured and New York ranks seventh among states on coverage. Narrowing this coverage gap is challenging and states have developed innovative strategies to meet the challenge, including state individual mandates, state premium assistance programs, coverage expansions, using tax returns to boost enrollment, and creating state-sponsored public options. New York could meaningfully reduce the number of uninsured people by adopting one or more of these strategies.

This paper provides a guide for New York policymakers to five strategies for increasing coverage rates.^[1] Each section describes design and implementation issues related to New York's health care environment and estimates the increase in enrollment and cost to the State. These estimates are based on State administrative data, federal data such as the U.S. Census, and evaluations of efforts implemented in other states.

“Narrowing the coverage gap is vitally important and would greatly benefit the health and finances of newly insured New Yorkers.”

The coverage gap is one barrier among many that reduces access to care, imposes extraordinary financial burdens on patients, lowers quality of care, and creates and perpetuates inequities. Other health system changes also are needed to address these problems, ensure the system is fiscally sustainable and improve access to high quality care. However, narrowing the coverage gap is vitally important and would greatly benefit the health and finances of newly insured New Yorkers. This report is intended to encourage robust debate about how to achieve that goal.

The 1 Million Uninsured New Yorkers

Individuals remain uninsured for one of four reasons: (1) they are unaware of or do not understand their coverage options and the enrollment processes; (2) they choose not to enroll for political or religious reasons; (3) they have a high risk tolerance and self-perceived good health status; or (4) they consider the coverage available to them to be unaffordable.

Prior to the pandemic and the recession it caused, roughly 1 million New Yorkers lacked

insurance. Assuming that 2023 insurance rates and distribution will mirror 2019, roughly 345,000 of these will be eligible for but not enrolled in public coverage options like Medicaid, the Essential Plan or Child Health Plus (CHP); another 421,000 will have access to employer or self-purchased coverage but have not enrolled due to cost, low perceived value, or other reasons; and 245,000 uninsured individuals will have an immigration status that renders them ineligible to participate in public programs like Medicaid, the Essential Plan, and Qualified Health Plans offered through the State's Marketplace.

Five Strategies to Narrow the Coverage Gap

This report analyzes five strategies for reducing the number of uninsured in these three groups.

One strategy, a state individual mandate, would have only a nominal effect. The others – enhanced outreach and enrollment, a public option, expanded eligibility for immigrants, and premium subsidies – would increase the number of people with insurance by between 10,000 and 92,000 if implemented alone. The largest effect was from premium subsidies at the highest amount modelled with an estimated annual State cost of up to \$803 million (\$8,500 per new enrollee). (See Table ES 1.) Some of these strategies can be mutually reinforcing, such as a mandate and premium subsidies, but for this paper each is estimated separately. Importantly, ranges of cost and coverage impacts have been estimated to appropriately reflect the specificity of the evidence and assumptions used. Generally, moderate estimates are presented to best convey the estimated magnitude of the impacts.

Strategy #1: State Individual Mandate and Penalty

New York could replace the federal mandate penalty that was repealed in 2018 with an identical policy at the State level. There is little evidence, however, that the federal mandate elimination had a negative effect on insurance rates in New York, so imposing a State mandate is unlikely to significantly increase the number of people insured. Still, the administrative cost would be nominal and the State could consider implementing a mandate to protect against individuals relinquishing insurance in the future and causing instability in the individual market.

Strategy #2: State Premium Assistance Program

People who earn between 200 percent and 400 percent of the federal poverty level (FPL) receive federal subsidies to buy individual market plans. The subsidies are calculated to cap the percent of their income they would need to use to purchase a Silver-level plan. However, many New Yorkers who would get these subsidies are not enrolled. New York could provide additional subsidies to reduce the cost of individual market plans for more people. Three premium subsidy designs were analyzed:

- Deep subsidies for people earning between 200 percent and 600 percent of the FPL that limit premium costs to between 1 percent and 6 percent of household income;
- Moderate subsidies for the same income levels that limit premium costs to between 3 percent and 8.5 percent of household income (which match the temporary enhanced subsidies created by the American Rescue Plan); and

- Subsidies only for those earning between 400 percent and 600 percent of the FPL that limit premium costs to 10 percent of household income.

The biggest effect is for the deepest subsidy, with a moderate estimate of 92,000 newly insured for an annual cost of \$803 million. The moderate subsidies would produce about 52,000 newly insured for a cost of \$371 million. The subsidies for people earning between 400 percent and 600 percent of FPL only would produce about 2,000 newly insured for an annual cost of \$15 million. Other effects were not modelled including increased revenue for health care providers and stable or lower premium costs as a result of increasing the size of the individual market.

Strategy #3: State Public Option Plan

New York could procure and offer a plan through the State Marketplace with lower premiums and less cost-sharing than plans currently available. It could do this by imposing stricter limits on administrative costs and profits for insurers and paying lower provider reimbursement rates than currently paid by New York’s commercial insurers. Effects were analyzed for a Gold-level and a Platinum-level plan. Bronze-level plans were excluded after preliminary analysis suggested this would not have an impact on coverage rates, and Silver-level plans were excluded to avoid disrupting federal premium subsidy calculations.

The moderate estimates of the number of newly insured individuals are 62,000 for a Gold plan and 45,000 for a Platinum plan. This strategy

would have little or no direct cost to New York State beyond marginal administrative costs. Federal costs would increase by between \$110 million and \$287 million for subsidies for the newly insured. There also could be significant impacts on providers (particularly safety-net providers with a lower portion of commercially insured patients), who would receive lower reimbursement rates for some of their patients, and on insurers, whose resources to pay for non-medical costs would be reduced for some of their members; these effects should be considered and are not modeled here.

Strategy #4: State Program for Low-income Immigrants

A large portion of uninsured New Yorkers are prohibited from federally-funded coverage options because they are undocumented or are lawfully present but remain ineligible for coverage due to their status. New York provides coverage to some members of this population through State-only funding for Medicaid and Child Health Plus, and could use a similar strategy to create a State-only funded Essential Plan. The Essential Plan is the brand name for New York’s Basic Health Plan and is fully funded by the federal government.

A State-funded Essential Plan that uses the same income eligibility (up to 200 percent of the FPL) would provide insurance for an estimated 46,000 new enrollees for an annual net State cost of \$345 million, accounting for savings from spending offsets for emergency Medicaid. Other effects were not modelled including increased revenue for health care providers.

Strategy #5: Enhanced Outreach and Enrollment Strategies

Enhancing outreach to the uninsured and providing more enrollment assistance would help insure more of the New Yorkers who are already eligible for low-cost coverage. Three strategies analyzed are:

- Expanding the Navigator program to enroll people in areas where more are uninsured than the state average. The remaining uninsured population is not evenly distributed across the state. New York could provide additional funding for

the State Navigator program to target areas where fewer people are insured than average. If New York increased insurance rates in those areas to the average (about 5 percent uninsured), an estimated 65,000 uninsured people would obtain coverage. Incremental costs for enrolling more people through the existing program would be up to \$300 per enrollee or about \$20 million in total.

- Enable enrollment through tax returns similar to the Maryland Easy Enrollment Health Insurance Program. Maryland’s tax returns ask individuals if they would like to check their eligibility for health

Table ES1: Summary of Coverage and Cost Estimates for Five Strategies, 2023

STRATEGY	MODERATE ESTIMATE (RANGES IN TABLE 2)		
	Newly Insured	Annual Net State Cost	Annual Net State Cost per Newly Insured
Individual Mandate	Nominal		
State Premium Assistance			
Deep Subsidies	92,000	\$803,000,000	\$8,700
Moderate Subsidies	52,000	\$371,000,000	\$7,100
Subsidies Above ACA Income Eligibility Only	2,000	\$15,000,000	\$8,000
Public Option			
Gold Benefit Levels	62,000	Nominal	Nominal
Platinum Benefit Levels	45,000	Nominal	Nominal
Immigrant Coverage	46,000	\$345,000,000	\$7,600
Enrollment and Outreach Enhancements			
Expanded Navigator Program	65,000	\$20,000,000	\$300
Tax Filing Outreach	10,000	Nominal	Nominal
Open Enrollment	Not Modeled		

insurance programs. People who qualify for Medicaid or CHP are sent plan options and are automatically enrolled if they do not respond. Those eligible for Marketplace coverage are given a special enrollment period. If New York had the same program outcomes as Maryland, an estimated 10,000 additional people would obtain health insurance.

- Expand enrollment opportunities outside of open enrollment. Uninsured New Yorkers who seek to purchase insurance outside of open enrollment can only do so under some circumstances including pregnancy, job loss, and moves. Massachusetts provides a special enrollment period for people who are buying Marketplace plans for the first time and earn up to 300 percent of the FPL. It also allows those who missed open enrollment to testify that their failure to enroll was unintentional and for those who lose coverage but miss the 60-day deadline to re-enroll to testify that they were unaware of the deadline. New York could adopt similar policies. The number of new enrollees and the possible market destabilization that could occur are not estimated. although there is no evidence of adverse selection or market destabilization from existing special enrollment periods in New York or in Massachusetts.

These strategies would increase the State's costs for the health insurance programs that enrolled more already eligible people. Those costs are not modelled. Like the other strategies, they would increase revenue for health care providers by reducing uncompensated care.

Conclusion

Increasing the number of insured New Yorkers will improve their health outcomes and economic security. The strategies and findings described in this paper are meant to stimulate and ground the debate on how to increase the number of New Yorkers that have health insurance.

Specific designs presented here are not exhaustive and permutations of each strategy exist and may be worthy of consideration. Some important effects of these initiatives, including those on the insurance marketplace, insurers, providers, and the cost of covering those already eligible, are not modelled here. These would have significant effects on New York's patients, the health care system, and the State budget and should be seriously considered by policymakers when choosing strategies to narrow the coverage gap. Still, this paper's findings, and strategies and designs should be productive starting points for discussion of the problem generally and each option specifically.

[1] This paper does not does not address a single-payer or universal coverage system for New York State, which was modelled in Jodi L. Liu and others, "An Assessment of the New York Health Act: A Single-Payer Option for New York State," (Rand Corporation, 2018), https://www.rand.org/pubs/research_reports/RR2424.html.

INTRODUCTION

Lack of health insurance is a serious problem for 29.6 million Americans including more than 1 million New Yorkers.¹ Research shows insurance coverage reduces morbidity and mortality experienced by uninsured patients and improves economic security by reducing medical debt and bankruptcy.² In addition, increased coverage benefits the nation as a whole. Public health efforts, including those to control COVID-19, are undermined when uninsured people avoid health care because of financial barriers. Lost productivity and debt acquired by the uninsured damages the economy.³ Additionally, health care providers lose an estimated \$42 billion annually caring for uninsured patients.⁴ These losses are partially offset by tax-funded uncompensated care programs that cost governments billions of dollars annually.⁵

The Patient Protection and Affordable Care Act of 2010 (ACA) significantly increased the number of people with health insurance nationally and in New York State. Between 2010 and 2019, the uninsured population nationally declined from 15.5 percent to 9.2 percent. New York's decline was greater, from 11.9 percent to 5.2 percent.⁶ Still, more than 1 million New Yorkers remained uninsured in 2019.⁷ Slightly over half lived in New York City (56 percent). The majority (87 percent) are ages 19 to 64, and nearly three-quarters of these working aged uninsured people are employed and earning below 400 percent of the federal poverty level (FPL).⁸

New York's uninsured fall into three groups:⁹

1. About 420,000 are people earning above 200 percent of the FPL and have access to private coverage through Qualified Health Plans (QHP) sold through the Marketplace established by the ACA or an employer. More than half of this group (roughly 260,000) are eligible for ACA subsidies that would offset their monthly premiums. Eligible individuals may choose not to enroll for various reasons including cost, low perceived value (for example, individuals who believe themselves to be healthy), or religious or moral objections to insurance.

Table 1: The Uninsured in New York State

	2023 (Projected)
Eligible to purchase Marketplace coverage, income at or above 200 percent of FPL	421,000
• Subsidy Eligible (200 to 400 percent of FPL)	259,000
• Not Subsidy Eligible (above 400 percent of FPL)	162,000
Immigrants currently ineligible for public or Marketplace coverage because of immigration status	245,000
Eligible but unenrolled in public coverage, income below 200 percent of FPL	345,000
TOTAL	1,012,000
Note: Sub-groups may not sum to total because of rounding.	

2. About 245,000 are individuals prohibited from enrolling in public programs like Medicaid and the Essential Plan (EP) or purchasing a QHP because of their immigration status. Most in this group have incomes that would make them eligible for Medicaid or EP if not for their immigration status.

3. About 345,000 are low-income individuals who qualify for existing public coverage options like Medicaid, Child Health Plus (CHP), or the EP because they earn below 200% of the FPL. In most cases these options are free or very low-cost for enrollees.

Table 2: Summary of Coverage and Cost Estimates for Five Strategies, 2023

Strategy	MODERATE ESTIMATE			RANGE		
	Newly Insured	Annual Net State Cost	Annual Net State Cost per Newly Insured	Newly Insured	Annual Net State Cost	Annual Net State Cost per Newly Insured
Individual Mandate	Nominal			Not Applicable		
State Premium Assistance						
Deep Subsidies	92,000	\$803,000,000	\$8,700	70,000 - 125,000	\$737,000,000 - \$892,000,000	\$7,100 - \$10,500
Moderate Subsidies	52,000	\$371,000,000	\$7,100	40,000 - 71,000	\$351,000,000 - \$399,000,000	\$5,600 - \$8,800
Subsidies Above ACA Income Eligibility Only	2,000	\$15,000,000	\$8,000	1,000 - 3,000	\$14,800,000 - \$15,200,000	\$6,400 - \$11,300
Public Option						
Gold Benefit Levels	62,000	Nominal	Nominal	48,000 - 85,000	Nominal	Nominal
Platinum Benefit Levels	45,000	Nominal	Nominal	34,000 - 62,000	Nominal	Nominal
Immigrant Coverage	46,000	\$345,000,000	\$7,600	30,000 - 61,000	\$292,000,000 - \$380,000,000	\$6,200 - \$9,700
Enrollment and Outreach Enhancements						
Expanded Navigator Program	65,000	\$20,000,000	\$300	Not Modeled		
Tax Filing Outreach	10,000	Nominal	Nominal	Not Modeled		
Open Enrollment	Not Modeled			Not Modeled		

This report describes New York’s current coverage landscape and then analyzes five strategies for reducing the number of uninsured. It does not include a single-payer system as a strategy, which has been modelled elsewhere. The strategies are:

- Strategy #1: A State individual mandate and penalty;
- Strategy #2: State-funded premium assistance;
- Strategy #3: Gold- or Platinum-level public option;
- Strategy #4: State-funded Essential Plan lookalike for excluded immigrants; and
- Strategy #5: Enhanced outreach and enrollment efforts using the Navigator program, tax returns, or open enrollment expansions.

For each strategy, this report describes design considerations, estimates the number of uninsured who would gain coverage, and when possible, estimates State costs and other fiscal implications.¹⁰ (See Table 2.) Some of the strategies can be mutually reinforcing, such as a mandate with penalty and premium subsidies, but for this paper the effects of each are estimated separately. Importantly, ranges of cost and coverage impacts have been estimated to appropriately reflect the specificity of the evidence and assumptions used. Moderate estimates are presented in the text to best convey the estimated magnitude of the effects while the full estimate ranges are provided in tables. The Appendix provides the methodology and assumptions used to produce the estimates.

“New York has frequently worked with the federal government to expand eligibility for jointly-funded coverage or used State funding to cover excluded populations (such as undocumented immigrant children). ”

The findings described in this paper are meant to stimulate the debate on how to reduce the number of New Yorkers without health insurance and help anchor it with credible evidence of implications of various approaches. They should be considered starting points for discussion of the uninsurance problem generally and each option specifically. Specific designs presented here are not exhaustive and permutations of each strategy exist and may be worthy of consideration. Other effects, such as changes in the health care delivery system, insurance markets and the cost of enrolling currently eligible individuals, are not modelled here. These could have significant effects on individuals, health care providers, the safety net system, insurers, and the State budget, and should be identified and seriously considered by policymakers exploring ways to narrow New York’s coverage gap.

BACKGROUND

New Yorkers obtain health coverage through a mix of private and public sources including employer-sponsored coverage. Medicare and Medicaid, created in 1965, and the Child Health Insurance Program, created in 1997, expanded the number of insured New Yorkers and provide billions of dollars in federal funding for coverage. New York has frequently worked with the federal government to expand eligibility for jointly-funded coverage or used State funding to cover excluded populations (such as undocumented immigrant children).

In 2010, the enactment of the ACA substantially improved access to public and private coverage for millions of Americans. For public programs, the ACA allowed New York to expand Medicaid eligibility to higher incomes and increased federal funding for some previously covered enrollees, including some that had been covered only using State funds.¹¹ New York is also one of two states to adopt the Basic Health Program under the ACA. The Basic Health Program, called the Essential Plan (EP) in New York, extends free or low-cost coverage to most individuals below 200 percent FPL who are not otherwise eligible for Medicaid, including many immigrants. It is described in more detail below.

The ACA also introduced four important reforms that helped create a robust individual market in New York. First, it mandated individuals to secure insurance that meets minimum standards or pay a tax penalty. The federal government effectively terminated the mandate in 2018 by reducing the penalty to \$0 and ending its enforcement.¹²

Second, the ACA set minimum standards for insurance benefits; QHPs are “qualified” because they meet these standards. For example, plans must provide a set of essential health benefits including hospitalization and pharmacy. The Marketplace QHPs are categorized in five “metal” tiers organized by actuarial value (AV). Actuarial value is the percent of costs the plan pays versus the amount the enrollee pays in deductibles, co-insurance, and copayments. The tiers are catastrophic (50-60 percent AV), Bronze (60-69 percent AV), Silver (70-79 percent AV), Gold (80-89 percent AV), and Platinum (90 percent or higher AV).¹³ Premiums become more expensive as the AVs increase, while other direct costs to the enrollee decrease (for example through lower deductibles). New York has codified these standards in State law.¹⁴

Third, the ACA offers federal financial assistance—called Advance Premium Tax Credits (APTCs)—to lower the cost of purchasing QHPs through the ACA Marketplaces. It provides these subsidies to individuals with incomes up to 400 percent of FPL (in 2021, \$51,520 for an individual and \$106,000 for a family of four) who do not have access to health insurance through an employer. For a two-year period (coverage years 2021 and 2022) the American Rescue Plan (ARP) enhanced subsidies across all income levels and expanded subsidies beyond 400 percent of FPL. The ACA also limits cost-sharing for people who earn between 200 percent and 250 percent of FPL through cost-sharing reductions (CSRs).

Finally, the ACA established Marketplaces where people can shop for insurance and determine their eligibility for subsidies. New York opted

to establish its own New York State of Health (NYSOH) Marketplace rather than use the federal Marketplace (Healthcare.gov). NYSOH offers a single website that determines eligibility for public coverage or ACA financial assistance (APTCs and CSRs) and facilitates enrollment.¹⁵ New York’s Marketplace also operates a call center and a statewide in-person Navigator program to provide additional enrollment assistance.

Because of these reforms, New Yorkers are better able to find, understand, and afford private individual market plans. New York now has one of the biggest and most competitive individual insurance markets in the country, with 12 insurers offering QHPs (the second most of any State). New Yorkers in every county have a choice between at least two insurers, and most have more (31 of the 62 counties have five or more insurers offering coverage).¹⁶

These market reforms and public coverage expansions have caused a substantial decrease in the number of people without insurance in New York. Prior to passage of the ACA, 11.9 percent of New York residents were uninsured. This dropped by more than half, to 5.2 percent, in 2019.

Current and Projected New York State Health Insurance Coverage Landscape

Table 3 shows how New Yorkers obtained health insurance in 2019 before the COVID-19 pandemic. The pandemic and associated recession caused shifts in health coverage enrollment, especially from employer-sponsored insurance to Medicaid or EP. This analysis assumes, based on projections of employment

and economic recovery, that the population and coverage mix in 2023 will be the same as in 2019. The effects of different policy options are estimated from that starting point.

In 2019, 51 percent of New Yorkers had private health insurance. Over 9.4 million had coverage

Table 3: Insurance Coverage Profile of New York State Population, 2019 and 2023 Projection with No Policy Intervention

	2019	2023 Projection (No Intervention)
Total Civilian Non-Institutionalized Population	19,243,000	19,243,000
Private Coverage		
Employer Based	9,438,000	9,438,000
Coverage Purchased On Marketplace (NYS)	272,000	272,000
Coverage Purchased Off Marketplace (NYS)	71,000	71,000
Other Private (e.g. purchased out of state)	43,000	43,000
Private Coverage Total	9,824,000	9,824,000
Public Coverage		
Medicaid & CHP	4,904,000	4,904,000
Essential Plan	790,000	790,000
Medicare	2,607,000	2,607,000
Other Public Coverage (e.g. TRICARE)	105,000	105,000
Public Coverage Total	8,406,000	8,406,000
Uninsured	1,012,000	1,012,000

through plans offered through their or a family member's employer or union. Many of those plans are regulated by the federal government rather than the State. Another 340,000 purchased individual coverage on- or off-Marketplace. About 44 percent of New Yorkers have public health insurance. Roughly 5 million are enrolled in Medicaid or CHP. About 2.6 million were enrolled in the Medicare program because they are over 65 or have disabilities. An additional 790,000 were enrolled in EP. One million (about 5 percent) were uninsured.¹⁷

Medicaid and CHP

In 2019, nearly 5 million people were enrolled in Medicaid or CHP in New York. New York's Medicaid program is available to people who earn below 138 percent of FPL, including some who are also enrolled in Medicare but need long-term care or other services that are not covered by Medicare. Some New Yorkers who meet income requirements for Medicaid are ineligible because of their immigration status. People enrolled in New York's Medicaid program pay no premiums, have no deductible, and have very low co-pays. Once someone is enrolled in Medicaid, they are covered for one year regardless of income changes.

CHP is available to New Yorkers between the ages of 0 and 19 regardless of immigration status. New York uses only State funds for immigrant children who are prohibited from federally-funded coverage. CHP is subsidized for families earning below 400 percent a year but is open as a public option for those with higher incomes who want to enroll at full cost.

Many New Yorkers can complete the eligibility determination and enroll in Medicaid or CHP through the NYSOH Marketplace. Some, such as those enrolling in Medicaid under special rules for people with disabilities, are required to enroll through local Departments of Social Services.

Essential Plan

EP became available in 2016 and in 2019 covered 790,000 New Yorkers. The number of people enrolled in EP has increased each year since it was established, reaching over 900,000 enrollees in 2021.¹⁸ The program was created through the ACA's Basic Health Program provision. It is funded by the federal government through a formula that provides approximately 95 percent of the APTCs and cost sharing subsidies that it would have paid if the individual enrolled in a Silver-level Marketplace plan.

EP is available for New Yorkers who earn up to 200 percent of FPL. This includes some immigrants who earn under 138 percent of FPL and are ineligible for federally-funded coverage under Medicaid rules but eligible under the ACA. New Yorkers who are eligible for EP become ineligible for APTCs for individual Marketplace plans. Coverage is free for enrollees—there are no premiums or deductibles—and benefits are comprehensive (including vision and dental) with a Platinum-level AV of 93 percent.¹⁹ Most insurers participating in the Marketplace participate in the EP, leveraging their QHP and Medicaid Managed Care networks. Every county in the State has at least two—and as many as seven—insurers offering EP in 2021.²⁰ EP plans

typically pay providers a rate equal to 120 percent of Medicaid rates; commercial insurance rates in New York average 159 percent of Medicaid rates.²¹ EP enrollment is done through NYSOH.

EP has allowed New York State to secure federal funding for some immigrants who were previously enrolled in Medicaid without federal Medicaid matching funds; funding was solely provided by New York State. This group of immigrants, referred to as the “Aliessa” population in reference to the *Aliessa v. Novello* case, are lawfully present immigrants who have been in the country for less than five years and most immigrants who have Permanently Residing Under the Color of Law (PRUCOL) status. EP enabled the State to shift this immigrant population from State-only funded Medicaid to federally-funded EP, saving New York State as much as \$1 billion annually.²²

Marketplace Coverage

Marketplace coverage is available for New Yorkers who do not have access to affordable employer- or union-sponsored insurance and earn too much for Medicaid or EP. Approximately 270,000 people were enrolled in QHPs through the Marketplace in 2019.²³ Forty-two percent were enrolled in Bronze plans, which have the lowest premiums but the highest deductibles and cost-sharing; 37 percent enrolled in Silver plans, 11 percent in Gold, and 8 percent in Platinum.²⁴

The ACA provides premium subsidies (APTCs) for individuals with incomes between 200 percent and 400 percent of FPL. The APTCs cap the percent of income people spend on premiums. The size of the APTC depends on the individual’s income and the cost of a benchmark plan (the

second lowest-cost Silver-level plan) being sold in their region. In this way, the subsidy is sensitive to local market prices, providing a greater subsidy where benchmark plans are more expensive.²⁵ In 2019, 58 percent of people who purchased a QHP through NYSOH received APTCs.²⁶ In 2021, Congress enacted the ARP, which provides enhanced subsidies for two years to individuals currently eligible for subsidies with incomes below 400 percent of FPL and, for the first time, offers subsidies to people with higher incomes, up to around 600 percent of FPL.

Off-Marketplace Coverage

Some New Yorkers purchase non-group coverage from insurers outside of the Marketplace. In 2019, more than 70,000 New Yorkers were enrolled in such plans.²⁷ Some of this group are enrolled in “grandfathered” (or pre-ACA) plans. The others are enrolled in plans that meet minimum requirements to be sold in New York State, such as covering the essential benefits designated by the ACA and participating in a public rate review process. These plans are identical to QHPs.

New Yorkers choose to purchase plans outside of the Marketplace for various reasons. Some individuals prefer to maintain their pre-ACA plans or to enroll in plans that are not available on the Marketplace. Immigrants who are not eligible to participate in the Marketplace may purchase coverage in the off-Marketplace individual market, if they have sufficient resources to do so. In general, individuals who are not eligible for ACA subsidies (those with incomes above 400 percent of FPL) have less incentive to purchase on the Marketplace than those eligible for subsidies.

Health Insurance Affordability in New York State

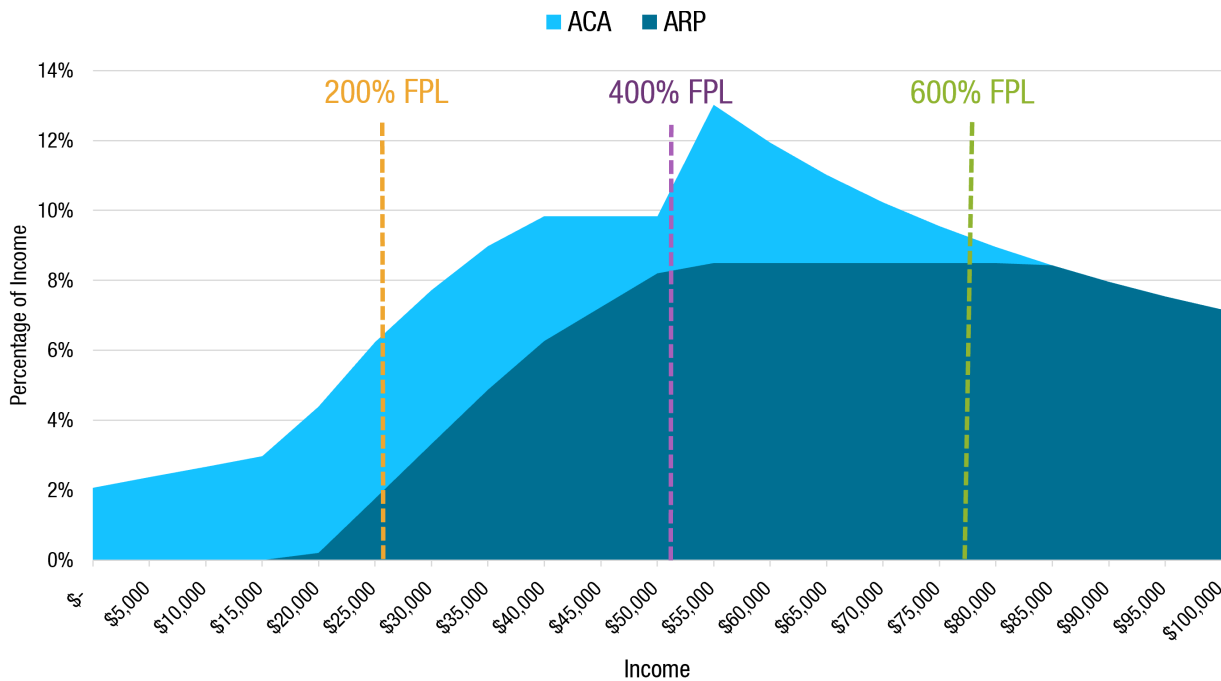
In 2019, about 420,000 uninsured individuals earned above 200 percent of FPL (too high for Medicaid or the Essential Plan) and were eligible to purchase QHPs. Within this group, more than half (260,000) had incomes which made them eligible for premium subsidies (between 200 and 400 percent of FPL).²⁸ The remaining 160,000 had incomes above 400 percent of FPL and would pay full premiums out-of-pocket.

Some of the people in this group decide against purchasing health insurance because they do not know what their options are, are not sure how

to enroll, have religious or political objections, or have a high-risk tolerance and hope to avoid using health care. However some remain uninsured because the plans available through NYSOH are unaffordable to them, even with APTCs, determining the monthly premiums are too expensive relative to the value of coverage (e.g. high deductibles, co-insurance and co-payments) and competing financial demands on a household budget. In 2019, 51 percent of uninsured New Yorkers said that premiums were too high for them to buy insurance.²⁹

Premium costs can be significant for the uninsured QHP-eligible population. Figure 1 illustrates the percent of income required to

Figure 1: Percentage Income Required to Pay for Benchmark Silver Premium, 2021



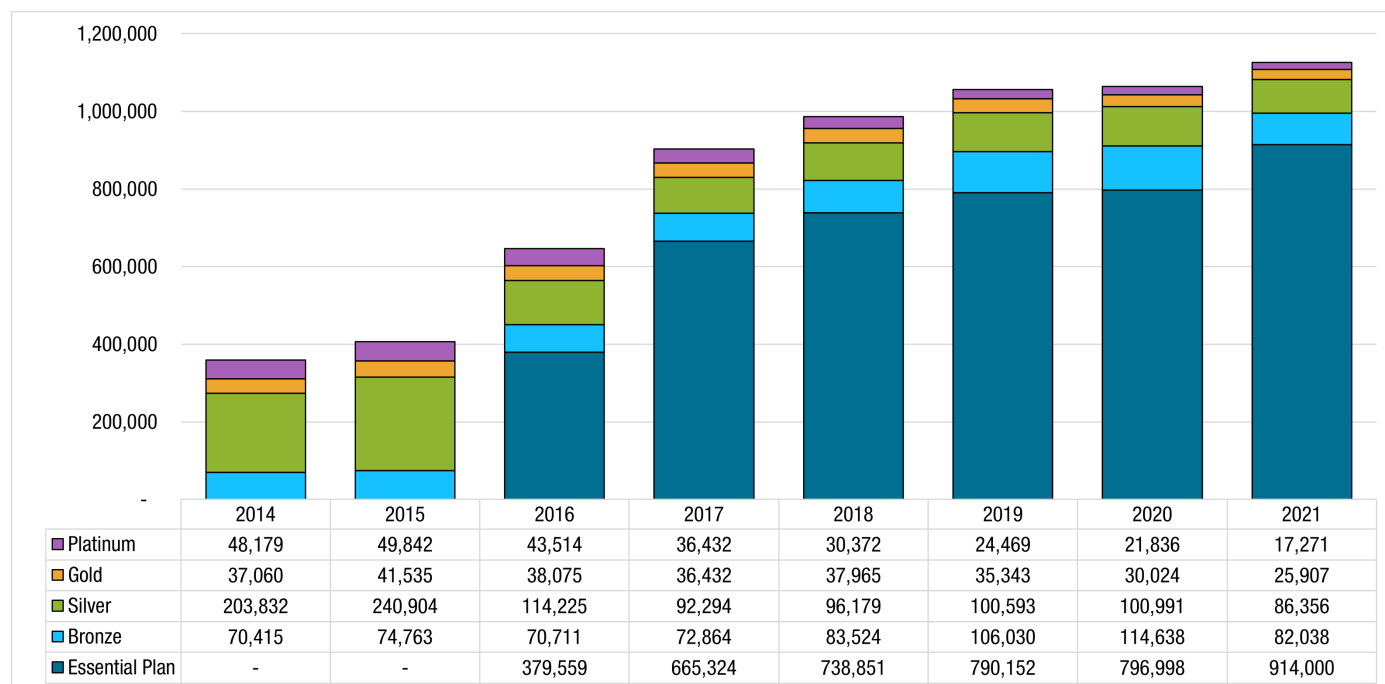
Sources: Authors' analysis of U.S. Department of Health and Human Services, "U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs" (accessed December 4, 2021), <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines>; and American Rescue Plan Act of 2021, P.L. 117-2.

purchase the benchmark Silver plan, which has an average \$2,558 deductible and an overall 70 percent AV. The lowest-income New Yorkers who might purchase QHPs (those earning above 200 percent of FPL and thus ineligible for EP) are eligible for APTCs that would reduce premium costs to 6.54 percent of their income when purchasing a benchmark plan. At 400 percent of FPL, the APTCs would bring premium costs down to 10 percent of their income for a benchmark plan. The ARP increased the amount of subsidies (for example, capping benchmark premium costs at 8.5 percent of income for those earning 400 percent of FPL) and added new subsidies for people

earning between 400 percent and 600 percent of FPL. This is likely to change some New Yorkers' affordability determination, but these higher subsidies are set to expire in 2023.

Enrollees can stretch their APTCs further by choosing Bronze plans, which have lower premiums but higher deductibles and cost-sharing. For example, in New York the premium cost of the average lowest-cost Silver plan statewide was \$558 in 2019 with a \$1,700 deductible, and the average lowest-cost Gold premium statewide was \$638 with a \$600 deductible.³⁰ Bronze plan deductibles ranged from \$4,700 to \$6,900.³¹ Enrollment in these

Figure 2: NYS Marketplace Enrollment by Plan Type, 2014 to 2021



Sources: New York State Department of Health, Health Insurance Coverage Update (September 2021), https://info.nystateofhealth.ny.gov/sites/default/files/Health%20Insurance%20Coverage%20Update%20-%20September%202021_0.pdf; and 2020 Open Enrollment Report (April 12, 2021), and prior editions, <https://info.nystateofhealth.ny.gov/sites/default/files/2020%20NY%20State%20of%20Health%20Open%20Enrollment%20Report.pdf>.

“In 2019, 51 percent of uninsured New Yorkers said that premiums were too high for them to buy insurance.”

plans provides benefits, including preventive care services, but the higher deductibles can increase enrollees’ risk of high medical bills. A large number of insured New Yorkers report that they have delayed care or suffered serious financial problems after obtaining care for that reason.³²

Prior to the ARP, Marketplace enrollees were increasingly opting for plans that have the lowest premiums and highest additional costs. Figure 2 illustrates the types of plans New Yorkers chose since the Marketplace launched. Two trends stand out. First, the comprehensive EP (with no premiums or deductible) has been the most successful in enrolling eligible individuals. Second, enrollees ineligible for the EP tend to choose low-cost Bronze plans, despite their providing limited financial protection.³³ From the time the Marketplace launched in 2013 to the 2020 enrollment period (prior to the pandemic), the number of enrollees in Platinum plans decreased 55 percent while the number in Bronze plans increased 63 percent. The trend toward low-cost plans has also been observed in other states.³⁴ With the enactment of the ARP, this trend started to reverse, indicating a demand for higher quality coverage.³⁵

STRATEGY #1: STATE INDIVIDUAL MANDATE AND PENALTY

Summary of Findings: A State individual mandate and tax penalty is intended to increase the number of insured by creating a financial disincentive to be uninsured. It would replace the ACA penalty, which was repealed at the federal level for 2017. Four states and the District of Columbia have adopted state-level mandates and penalties. Administrative costs would be minimal. Evidence from the implementation and subsequent repeal of the federal individual mandate and penalty suggests that a similar State-based policy is likely to have little to no impact on overall enrollment.

Background

The ACA’s individual mandate provided a financial incentive for healthy individuals to acquire coverage using a tax penalty. The purpose of an individual mandate is to reduce “adverse selection” in the insurance market. Adverse selection is a term that describes what happens to insurance markets when healthy people do not sign up for coverage because it is too expensive or they do not have an incentive to join, leaving only sick people in the risk pool. Risk is not spread evenly between the sick and healthy populations and premiums increase when only sick people enroll in coverage. If adverse selection occurs to an extensive degree, the individual market enters a “death spiral” in which continually increasing premiums push out relatively healthy individuals.

Until 2019, the ACA’s individual mandate was enforced by tax penalties as the larger of \$695

annually for adults (and half that for children) or 2.5 percent of household income. It was capped at the national average premium of a Bronze plan. The penalty was prorated for the share of the year during which an individual was not insured.³⁶ Enforcement was the responsibility of the federal Internal Revenue Service (IRS) with individuals documenting coverage with their tax returns and penalties imposed as additions to their tax liability. Exemptions to the mandate were available for a variety of circumstances the most important of which are people not lawfully present (meaning immigrants barred from participating in many forms of insurance coverage), religious objections, and for individuals for whom the cost of mandated coverage exceeds 9.78 percent of household income.³⁷

The federal Tax Cuts and Jobs Act of 2017 effectively repealed the federal mandate by eliminating the penalty. Beginning in 2019 individuals were not subject to a penalty when filing their tax return for that year. In 2018, New Jersey and the District of Columbia enacted state individual mandates effective in 2019, and Vermont enacted one effective in 2020. In 2019, Rhode Island and California enacted state individual mandates effective in 2020. The enrollment trends in each state following implementation of an individual mandate do not reflect a clear trend or pattern: in New Jersey, Vermont, and the District of Columbia enrollment decreased in the first year, in California enrollment increased, and in Rhode Island enrollment was essentially unchanged.³⁸

Nationally, the IRS reports that in 2016 (the latest available year) slightly fewer than 5 million

tax returns included a penalty; total penalty amounts were about \$3.6 billion, indicating an average penalty of \$728.³⁹ In 2016, New York reported 280,750 returns with a penalty. The total amount collected was \$201.6 million for an average penalty of \$718. The number of 2016 returns with a penalty was about 30 percent less than in 2015 (405,610) because of full implementation of New York's Essential Plan.⁴⁰

Research on the impact of the mandate has had conflicting results. A national study of the effects of the ACA in 2014 and 2015 found that the premium subsidies and Medicaid expansion rather than the mandate accounted for most of the increase in coverage, but that the mandate encouraged enrollment among the entire population.⁴¹ A study focusing on non-elderly adults with incomes above 400 percent of the FPL found that among that income group the decline in the share uninsured from before ACA (2013) to 2016 was 2.13 percentage points from 5.53 to 3.42 percent.⁴² Another found that the mandate has a generalizable if small effect even on people who are not subject to the penalty.⁴³

Two studies were issued in 2018 that projected the impact of the elimination of the federal mandate for New York. The RAND Corporation projected that the elimination of the penalty in 2019 would increase the number of uninsured by 21 percent or 292,000; of which the greatest increase would be among those previously purchasing unsubsidized individual coverage.⁴⁴ The Urban Institute simulated the impact of a state mandate for New York State and projected a reduction of 142,000 or 10 percent in the number of uninsured in 2019.⁴⁵

However, evidence from New York’s 2019 open enrollment period, the first without a federal penalty, indicates that New York’s individual market did not respond as projected. Enrollment through New York’s Marketplace in QHPs increased 7 percent, with gains in both subsidized and unsubsidized purchases. Essential Plan enrollment likewise increased about 7 percent.⁴⁶ It should be noted, however, that the number of people purchasing individual plans off-exchange declined from 92,000 to 71,000, though the decrease is hard to attribute to any specific cause.⁴⁷ In 2020 and 2021, Marketplace enrollment has been affected by the COVID-19 pandemic, which caused shifts in coverage because of changes in employment and featured longer open enrollment periods. Total enrollment in the Essential Plan QHPs increased in both 2020 and 2021, continuing enrollment gains after repeal of the federal mandate.⁴⁸

Design Considerations for a State-Level Individual Mandate

Design considerations for a state mandate are the penalty amount, the exemptions, and rules about who is considered insured. Design structure and enforcement would also drive costs of administering the mandate. Some guidance is available from other states. State programs generally parallel the original federal mandate, typically granting exemptions with similar affordability criteria and other exclusions including undocumented immigrants. The maximum penalty typically is tied to the premium for Bronze plans based on the state-specific average rather than the national average. Vermont altered its original plan and eliminated a financial penalty but requires reporting of non-coverage with tax returns in order to facilitate outreach.

An additional consideration is the indirect impact of a mandate on QHP premiums. Because a mandate is intended to combat adverse selection, it is expected to reduce morbidity in the risk pool and thereby reduce QHP premiums. For example, in 2018–following repeal of the federal mandate–New York State incorporated rate increases for QHP plans associated with the anticipated increase in morbidity among the QHP population because of healthier individuals dropping coverage. If New York were to implement a State mandate, these rates might be reduced by a similar factor. To the extent such premium reductions impact the benchmark Second Lowest Silver Plan, this would lower APTCs available to consumers and the funding available for the Essential Plan.

Change in Insurance Coverage and Fiscal Effects

States adopting individual mandates assumed that it would reverse the impact of the 2019 effective repeal of the federal mandate, which was originally implemented in 2013. However, it does not appear that the adoption of the individual mandate had any discernable impact on New Jersey’s enrollment. Moreover, the repeal of the federal mandate has had no measurable impact on coverage in New York. Accordingly, this analysis concludes that implementation of a State mandate is unlikely to have a significant effect on overall insurance coverage and coverage decisions by New Yorkers. Still, since a State mandate may have an effect on some New Yorkers’ choices and its likely nominal administrative costs could be offset by penalties, its implementation may possibly yield some modest coverage benefits.

STRATEGY #2: STATE PREMIUM ASSISTANCE PROGRAM

Summary of findings: A New York State-level premium assistance program would reduce the number of uninsured by providing additional State-funded subsidies to lower premium costs.

Three design options are modeled based on the generosity of the premium assistance and the level of income of the recipients: (1) a deep subsidy program would increase the number of insured about 92,000; (2) a moderate subsidy program (similar to the enhanced subsidies available under the American Rescue Plan) would increase the number of insured by about 52,000; and (3) a subsidy program only for the highest income group would increase the number of insured by about 2,000.

A premium assistance program would provide subsidies to individuals who are currently uninsured as well as additional subsidies to people who already have Marketplace coverage. Assuming a moderate price elasticity, in total

(including both uninsured and previously insured individuals) a State premium assistance program would benefit an estimated: 319,000 individuals in the deep subsidy program; 270,000 individuals in the moderate subsidy program, and 47,000 individuals in a program targeted only to people with higher incomes.

The estimated net State cost of the program would be: \$803 million a year for the deep subsidy option; \$371 million for the moderate subsidy option; and \$15 million for a program that targets only those with higher incomes. Depending on which strategy is adopted, this program could reduce uncompensated care costs by \$2 million to \$108 million.

Background

In 2019, before the implementation of the ARP, there were about 420,000 uninsured New Yorkers whose incomes were either too high to qualify for the State's public insurance programs or who had determined that private coverage is unaffordable or had another reason for not enrolling in coverage.⁴⁹ About 260,000

Table 4: State Premium Assistance Program Impact Summary (moderate estimates)

Impact	Schedule 1: Deep Subsidies	Schedule 2: Moderate Subsidies	Schedule 3: High Income Only Subsidies
Newly Insured	92,000	52,000	2,000
Previously Insured	227,000	218,000	45,000
Total Beneficiaries	319,000	270,000	47,000
Total Net State Cost	\$803,000,000	\$371,000,000	\$15,000,000
Net State Cost per Newly Insured	\$8,700	\$7,100	\$8,700
Provider Uncompensated Care Savings	\$108,000,000	\$61,000,000	\$2,000,000

individuals in this group are estimated to be eligible for APTCs through the Marketplace, but remain uninsured.

Many uninsured people who are eligible for APTCs under the original ACA schedule confront a steep affordability cliff at 200 percent of the FPL (around \$25,700 per year for an individual). People with incomes below that cliff are eligible for the premium-free Essential Plan or Medicaid. By contrast, even with APTCs, an individual who makes 250 percent of FPL (around \$32,000 per year) would pay about \$220 a month, or \$2,640 for a year, for a Silver plan with a \$1,300 deductible. As an individual's income goes up the income ladder to 400 percent of FPL, the APTCs become smaller and premiums increase to \$420 per month for a Silver plan, even with financial assistance. Accordingly, many New Yorkers eligible for subsidies do not obtain coverage because of the relatively high premium cost or perceived low value. Additionally, people with incomes above 400 percent of FPL (\$51,520 per year) receive no assistance at all and would pay \$565 per month for the cheapest Silver plan.⁵⁰

The federal ARP law provides temporary enhanced premium assistance for the 2021 and 2022 coverage years to Marketplace enrollees in New York with incomes above 200 percent of FPL. As displayed in Figure 1, this assistance decreases on a sliding scale, ending a little above 600 percent of FPL. Under the ARP, an Albany resident who makes 250 percent of FPL receives approximately \$458 in monthly subsidies, paying \$107 instead of the \$220 a month described in the scenario above. ARP also benefits people above 400 percent of FPL. Under ARP, an

individual with an income of 450 percent of FPL (\$58,080) receives \$154 in subsidies, instead of \$0, and would pay \$411 for the cheapest Silver plan, instead of \$565.⁵¹

A State premium assistance program would provide a financial incentive for individuals to purchase coverage on the Marketplace by lowering their direct premium costs. At least three other states have taken this approach, described below. The Urban Institute and the Commonwealth Fund also have estimated the effects of increasing federal premium assistance and found that an additional 4.6 million people could be insured by spending \$24.5 billion (when paired with an individual mandate).⁵²

Design Considerations

Design features of a state premium assistance program include: the income eligibility criteria for receipt of premium assistance; the depth or amount of the premium assistance; and immigration status of those receiving the state premium assistance.

Other states offer guidance about the levels of income eligibility. Massachusetts and Vermont offer state premium assistance to QHP enrollees below 300 percent of FPL, who are already eligible for APTCs.⁵³ By contrast, in 2019, California enacted a state premium assistance program that benefits people with incomes up to 600 percent of the FPL.⁵⁴ An estimated 120,000 Californians who earn between 400 and 600 percent of FPL would receive subsidies for the first time, and enhanced subsidies would go to an existing 680,000 enrollees between 200 and 400 percent of FPL for a total of 780,000 beneficiaries.⁵⁵ Experts estimate that premiums

would decrease by 8.5 percent because of the increased enrollment of healthier individuals into the California individual insurance market.⁵⁶

The second design feature concerns the amount of the premium assistance to be offered. Three designs schedules are modeled here. (See Table 5.) Schedule 1 offers the most financial assistance, requiring individuals to spend between 1 percent to 6 percent of income for premiums. Schedule 2 offers more moderate financial assistance, requiring individuals to spend from 3 percent to 8.5 percent of their income for premiums, which is similar to the enhanced subsidies available under the ARP. Schedule 3 offers subsidies only to people at 400 to 600 percent of the FPL and requires them to pay 10 percent of income for premiums, continuing the federal subsidy level currently available to those from 300 to 400 percent of the FPL to higher income individuals at State expense.

A final program design feature concerns whether to offer the state premium assistance program to

immigrants who are currently ineligible for ACA subsidies. No state has yet to offer state premium assistance to purchase QHPs to immigrants who are ineligible for APTCs. But a few states have expanded their Medicaid program to cover some of these immigrants (e.g., young adults in California and seniors in Illinois). The options modeled here exclude currently ineligible immigrants because Strategy #4 explicitly addresses an option for low-income members of that group.

Table 6 shows the maximum amount an individual at selected income levels would pay for insurance under each program. Schedules 1 and 2 smooth the existing affordability cliff at 200 percent of the FPL. Under Schedule 1, New Yorkers at 250 percent of the FPL would pay \$29 a month for a Silver plan with a \$1,300 deductible compared to paying no premium (and having no deductible for the EP program for those just under 200 percent of FPL). Under Schedule 2, New Yorkers earning just above 200 percent of the FPL would pay \$86 a month for a Silver Plan.

Table 5: Maximum Percent of Modified Adjusted Gross Income Required for Premiums Under Three State Subsidy Programs

Percent of FPL	Maximum Premium as Share of MAGI			
	ACA Subsidy Schedule	Schedule 1 (Deep Subsidy)	Schedule 2 (Moderate Subsidy; Similar to ARP)	Schedule 3 (High Income Only Subsidy)
200-250%	6.54-8.36%	1%	3%	No change from ACA Subsidy Schedule
250-300%	8.36-9.86%	2%	5%	
300-400%	10%	4%	7%	
400-600%	NONE	6%	8.5%	10%

Changes in Insurance Coverage and Fiscal Effects

A New York State premium assistance would benefit three groups: (1) uninsured people who would enroll in Marketplace plans; (2) people currently enrolled in Marketplace plans, who would receive financial assistance or additional financial assistance; and (3) people previously enrolled in off-Marketplace plans who would switch into coverage through the Marketplace and receive financial assistance for the first time.

The number of people who would become insured or would move from off-Marketplace to Marketplace coverage under each program depends on the price elasticity for each group. The estimates here assume that the price elasticity of demand for coverage (that is, the rate at which uninsured people choose to take-up coverage) is lower than the elasticity among those who are currently insured and deciding whether to change from one type of plan to another. The modeling also recognizes the uncertainty around estimates of each type of

price elasticity. Each type of elasticity is given a high, moderate, and low value, and the range of responses is calculated and presented in the Methodology Appendix.

Table 7 shows the estimated number of uninsured people benefitting from the two schedules of premium assistance using moderate elasticity of demand functions. Under Schedule 1, which provides the most financial assistance (deep subsidies), about 92,000 currently uninsured individuals would gain coverage. An additional 205,000 currently insured people with Marketplace coverage and 22,000 people with off-Marketplace coverage also would benefit from this program with added or new subsidies. Altogether, Schedule 1 would provide a total of 319,000 people would receive additional subsidies, for an estimated cost to the State of \$803 million, or \$8,700 per newly insured beneficiary.

Schedule 2 would attract fewer people into QHPs who are uninsured, because the subsidies are more modest than those offered

Table 6: Maximum Monthly OOP Premiums for Individual Benchmark Silver Plan Under the ACA and Three State Subsidy Programs

2023 Est Annual Income (FPL Cutoffs)	ACA Subsidy Schedule	Schedule 1 (Deep Subsidy)	Schedule 2 (Moderate Subsidy; Similar to ARP)	Schedule 3 (High Income Only Subsidy)
\$34,200 (250%)	\$239	\$29	\$86	\$239
\$41,100 (300%)	\$338	\$68	\$171	\$338
\$54,800 (400%)	\$457	\$183	\$320	\$457
\$68,500 (500%)	Full premium	\$342	\$485	\$571
\$82,200 (600%)	Full premium	\$411	\$582	\$685

in Schedule 1. An estimated 52,000 uninsured individuals would gain coverage. In addition, 205,000 individuals currently insured through the Marketplace and 13,000 individuals currently insured in off-Marketplace plans would benefit from added or new premium assistance subsidies. Altogether, Schedule 2 would provide a total of 270,000 people additional subsidies at an estimated cost to the State of \$371 million, or \$7,100 per newly insured beneficiary.

Schedule 3 would provide financial assistance only to people with incomes between 400 percent and 600 percent of the FPL. The subsidies would be minimal because the cost of the benchmark Silver plan being only slightly above 10 percent of FPL for members of this group. Under the moderate price elasticity assumption, this program would encourage only about 1,500 uninsured people to purchase coverage, and would encourage an additional 500 people to move from off-Exchange coverage to Marketplace QHPs.⁵⁷ However, about 45,000

people above 400 percent of the FPL who already purchase QHPs (at full premium) would receive financial assistance for the first time.

Table 7 indicates the relative effectiveness of each premium assistance schedule at targeting the uninsured. Schedule 1 benefits 319,000 people, of which 92,000 or about 30 percent would be newly insured. Schedule 2 benefits 270,000 people of which about 52,000 or 20 percent would be newly insured. Schedule 3 benefits about 47,000 people, of which about 2,000 or less than 5 percent would be newly insured.

The gross costs of a State subsidy include the direct cost of the new subsidies and additional costs incurred by the federal government for ACA subsidies for those switching from off-Marketplace to QHP plans. The State also would incur some added costs for administering additional subsidies through NYSOH, but these are expected to be modest and are not estimated here. The State premium assistance program

Table 7: People Benefiting from New State Premium Subsidies (Moderate Take-Up Scenario)

Income	Subsidy Schedule 1 (Deep Subsidies)			Subsidy Schedule 2 (Moderate Subsidies; Similar to ARP)		
	Previously Uninsured	Off-Marketplace Moving to On-Marketplace QHPs	Currently Enrolled in On-Marketplace QHPs	Previously Uninsured	Off-Marketplace Moving to On-Marketplace QHPs	Currently Enrolled in On-Marketplace QHPs
200-400% FPL	76,000	17,000	159,000	45,000	11,000	159,000
400-600% FPL	16,000	5,000	45,000	7,000	2,000	45,000
Total	92,000	22,000	205,000	52,000	13,000	205,000
Grand Total	319,000			270,000		

would generate additional HCRA taxes billed to those newly insured. Providers also would benefit from reduced uncompensated care costs because fewer patients would be uninsured.

Table 8 summarizes the estimated fiscal impacts. Schedule 1 annually would increase federal costs an estimated \$349 million and State costs \$803 million, while saving providers \$108 million in uncompensated care costs. Schedule 2 would increase federal costs an estimated \$218 million and State costs \$371 million, while saving providers \$61 million. Schedule 3 would not increase federal costs, but would increase State costs \$15 million and save providers \$2 million in uncompensated care costs.

Finally, as noted above, the expansion of coverage among relatively healthy individuals would likely lead to a reduction in QHP premiums, which could impact financing of the EP and the size of ACA subsidies linked to the benchmark premium for the second lowest cost Silver plan. The magnitude of these changes have not been estimated.

STRATEGY #3: STATE PUBLIC OPTION PLAN

Summary of findings: A New York State-sponsored public option health plan would aim to improve access to coverage by providing a high-value, reduced-cost option. Lower health plan overhead and provider reimbursement rates would provide a plan with lower out-of-pocket costs for enrollees at a high actuarial value.

A Gold public option plan would increase enrollment into health coverage by about 62,000. Another 18,000 individuals would switch to the public option plan from previous off-Marketplace individual coverage. This option would have marginal administrative costs to New York State, but would require between \$163 million and \$287 million in additional federal spending for subsidies for the newly insured.

A Platinum public option plan would lead to about 45,000 New Yorkers becoming newly insured, plus an additional 13,000 individuals

Table 8: State Premium Assistance Program Fiscal Impacts

Impact	Schedule 1 Moderate Estimate	Schedule 2 Moderate Estimate	Schedule 3 Moderate Estimate
Added Federal Subsidies	\$349,000,000	\$218,000,000	\$0
State Subsidy Gross Cost	\$820,000,000	\$381,000,000	\$15,000,000
New State HCRA Revenues	\$17,000,000	\$10,000,000	<\$1,000,000
Net State Incremental Cost	\$803,000,000	\$371,000,000	\$15,000,000
Net State Incremental Cost per Newly Insured	\$8,700	\$7,100	\$8,700
Provider Uncompensated Care Savings (\$ in millions)	\$108,000,000	\$61,000,000	\$2,000,000

would switch to the public option plan from previous off-Marketplace individual coverage. This option would have little or no direct cost to New York State, but would require between \$110 million and \$194 million in additional federal spending for subsidies for the newly insured.

Background

A public option strategy increases affordability by providing coverage at a lower cost than existing Marketplace and off-Marketplace plans. This option may be especially attractive to the uninsured who have decided that current coverage options are not worth their premium cost. Of the approximately 420,000 uninsured individuals estimated in 2023 to be eligible to purchase a QHP, 260,000 have incomes between 200 percent and 400 percent of the FPL and

therefore qualify for APTCs. The remaining 160,000 have incomes above 400 percent of the FPL and would pay full premiums costs. (See Table 10.) The State can make high-value coverage more affordable for these groups by making a lower premium plan available as a “public option.”⁵⁸

A public option plan could provide lower-cost coverage to enrollees because the State could directly regulate and set the plan design, control the provider reimbursement levels, and reduce health plan administrative costs and profits. The State has experience designing and procuring coverage in its Medicaid and Essential Plan programs and through its government employee health plan. The State would leverage its purchasing, design and regulatory powers to

Table 9: State Option Plan Impact Summary

	Gold AV Option	Platinum AV Option
	Moderate Scenario	Moderate Scenario
Total Beneficiaries (new Marketplace enrollees)	80,000	58,000
Beneficiaries Gaining Insurance Coverage	62,000	45,000
Direct Program Costs		
- Federal APTCs	\$214,000,000	\$145,000,000
- State Expenditures	0	0
State HCRA Revenue	\$9,000,000	\$6,000,000
Uncompensated Care Savings	\$73,000,000	\$53,000,000

offer plans at lower premiums than most private plans to lower the cost for current enrollees and increase the number of people enrolled in coverage.

Some states are considering or implementing public option plans because fewer plans are participating in their individual market. Nationally, 6 percent of enrollees lived in counties that had only one plan available for purchase on ACA Marketplaces in 2014. By 2019 that figure rose to 17 percent.⁵⁹ In response to these changing market conditions, some states have created or pursued public options:

- Washington. In May 2019, Washington enacted legislation to create the nation's first public option plan. The limited choice of QHPs offered on the Marketplace precipitated the State's decision.⁶⁰ The public option was offered on the Marketplace in the 2021 coverage year through multiple private insurers.⁶¹ The plan caps provider reimbursement rates at approximately 160 percent of Medicare. A higher rate floor of 101 percent of costs is set for critical access and sole community hospitals, and a floor of 135 percent of Medicare is set for primary care services. At the outset the plan does not offer additional financial assistance to enrollees, but the State may study that option further. Public option plans are required to adhere to a standardized plan design that encourages high-quality coverage. The public option's first coverage year was affected by the COVID-19 pandemic and 1,872 individuals enrolled in the public option (of 220,000 Washingtonians who enrolled

“A public option plan could provide lower-cost coverage to enrollees because the State could directly regulate and set the plan design, control the provider reimbursement levels, and reduce health plan administrative costs and profits.”

in Marketplace coverage). The relatively small enrollment is due partly by a plan only being available in roughly half of the state's counties and limited participation by major hospitals. Going forward, the state is hoping that the five participating carriers will offer the plan in additional counties, and is encouraging greater participation from hospitals.⁶²

- Colorado. Colorado is developing a public option to begin enrollment in 2023.⁶³ Like Washington, Colorado has a decreasing number of QHP carriers and high costs: 10 of 64 counties had only one plan available in 2021—all counties had three or more plans in 2014—and the state has some of the highest hospital costs in the country.⁶⁴ The framework for its public option plan is similar to Washington's with the state aiming to offer Silver, Gold, and Platinum public option plans in each county. The State is requiring plans to reduce premiums relative to current levels, and has estimated that premiums will be 9 to 18 percent less than existing plans.⁶⁵

- Nevada. In 2021, Nevada passed legislation to establish a public option plan starting in 2026, which will be sold at the Silver and Gold tiers. Most design components have yet to be determined, but premiums are expected to be 15 percent lower than existing non-public option plans and provider reimbursement rates to be equal to or greater than Medicare. Like Washington and Colorado, the public option design is set by the state and will be administered by commercial plans.

New York’s context is different from these states. New York has one of the most competitive QHP markets in the country with over a dozen carriers offering an array of standard and nonstandard benefit plans. None of New York’s counties has fewer than two options. Since New York has multiple plan choices in all counties, the public option’s purpose would be to address consumers’ affordability concerns. Higher actuarial value plans are relatively expensive, and the remaining uninsured may not be motivated to enroll in lower actuarial value plans that are more affordable or even free for them (with APTCs) because of large deductibles and cost-sharing. A public option could provide higher actuarial value plans with lower premiums and out-of-pocket costs.

Design Considerations

To provide a more affordable option to consumers above 200 percent of FPL purchasing Marketplace coverage while maintaining the structure of the current QHP market, the State could procure plans with a design that achieves premiums below current QHP levels in each

region and metal level. Key design choices for this plan include: (1) the richness of the plan’s benefit design in terms of AV or metal level; (2) the provider reimbursement rates; and (3) the amount an insurer is allowed for administrative costs, profits, and taxes.

First, this analysis models two benefit design alternatives—a Gold plan and a Platinum plan. Offering these plans at the Gold or Platinum actuarial levels would avoid a direct impact on the Silver tier, which determines premium subsidy calculations for QHP and the amount of federal funding for the State’s Essential Plan. Plans with both metal levels could be offered simultaneously instead of as alternatives, however, the required actuarial analyses to assess the interaction and overall enrollment at each metal level was not conducted for this paper. Preliminary analyses determined that a Bronze plan would not substantially increase coverage, would concentrate any benefit among higher income individuals, and could destabilize the existing robust Bronze QHP market.

Second, reducing reimbursement rates for the public option plan can lower the public option plan’s premium costs for the same benefit design as the QHPs.⁶⁶ Most QHPs pay providers negotiated rates that generally are higher than those of public plans. For example, in New York, commercial plan provider reimbursement rates are roughly 159 percent of Medicaid rates, while EP reimbursement is roughly 20 percent higher than Medicaid rates.⁶⁷ The public option plan could target provider reimbursement rates that are lower than current QHPs but higher than current EP.

Third, a public option can be designed to lower costs by decreasing the percentage of premiums insurers are allowed to support their overhead—such as administrative and marketing costs and profits. This could be accomplished by establishing a higher insurer Medical Loss Ratio (MLR) benchmark. An MLR is the percentage of the premium which is dedicated to pay health care claims. A public option plan could offer lower premiums if it were designed to require an MLR that is higher than the QHPs benchmark, which is 82 percent in New York State, but lower than those MLRs typically realized by the EP plans (roughly 90 percent).

Limiting provider reimbursement rates and increasing MLR requirements would generate savings for consumers, but those savings would come from providers and plans. While both providers and plans would benefit from more individuals being enrolled and accessing services, this benefit could be offset by disruptions to existing delivery systems and insurance markets. Additional modeling would be required to determine the net impact on

these parties, and careful design consideration would be required to ensure the stability of existing provider systems, especially those safety net systems with a lower portion of commercially insured patients, and insurers and their participation in the Marketplace and other public programs.

Changes in Insurance Coverage and Fiscal Effects

In 2023, an estimated 750,000 individuals above 200 percent of the FPL would be eligible to participate in a public option plan. Of these, 270,000 (36 percent) already would be enrolled in QHP plans, 60,000 (8 percent) would be in off-Marketplace individual plans, and 420,000 (56 percent) would be uninsured. The eligible population for the public option will be limited to those currently eligible to purchase coverage through the Marketplace.

These enrollment estimates follow the same approach as used for a Premium Assistance Program (Strategy #2). Different elasticities are assumed for the decision to purchase coverage

Table 10: Public Option-Eligible Population, 2023

	200 to 400 percent of FPL	400 to 600 percent of FPL	Above 600 percent of FPL	TOTAL
Marketplace QHP Enrollees	160,000	45,000	65,000	270,000
Off Marketplace Individual Market	30,000	10,000	20,000	60,000
Uninsured QHP-eligible Population	260,000	85,000	75,000	420,000
TOTAL	450,000	140,000	160,000	750,000

Source: See methodological appendix for more details on population estimates.

(price elasticity for coverage) and for the decision to switch among plans (price elasticity for plan choice). For each type of price elasticity, a range of assumptions is utilized to reflect the uncertainty in the analysis.

The lower premium of a State public option plan would affect coverage in three ways: (1) some currently uninsured will choose to purchase coverage; (2) some individuals with off-Marketplace coverage will switch to the new plan; and (3) some individuals with other QHP coverage will switch to the new plan. In each case the magnitude of the impact is a function of the level of savings in out-of-pocket premium cost in the new plans relative to currently available Marketplace plans, and the price elasticity for the affected individuals.⁶⁸

The difference in out-of-pocket premium costs for potential enrollees varies by the amount of APTCs associated with the individual's income.⁶⁹ Since current out-of-pocket premium levels are lower for lower-income individuals who receive larger APTCs, the proportional difference in premium costs between the current lowest cost plan in a given metal tier compared

to a State public option plan in that same metal tier is larger than for higher income individuals. For a Gold public option plan, a 25 percent reduction in total premium costs would reduce out-of-pocket premium costs (premium share offset by APTCs) for individuals with income below 250 percent FPL by 55 percent. However, this same reduction in total premium costs would only reduce out-of-pocket premium costs for individuals above 400 percent FPL by 25 percent since they do not receive APTCs in either scenario. At each income level, the percent reduction in out-of-pocket premium cost is multiplied by the price elasticity to determine the take up rate.

Based on these design parameters and using the moderate price elasticity scenario, an estimated 80,000 individuals (62,000 previously uninsured and 18,000 from off-Marketplace plans) would enroll in a Gold public option plan. (See Table 11.) About three-quarters (45,000) are estimated to have incomes between 200 percent and 400 percent of the FPL and be eligible for federal subsidies. The number of people who previously had QHP coverage switching to the new Gold

Table 11: Number of People Enrolling in Gold Public Option Plan (Moderate Take-Up Scenario)

Income (FPL Range)	Previously Uninsured	Off-Marketplace Moving to On-Marketplace QHPs	Total
200-400%	45,000	11,000	56,000
>=400%	17,000	7,000	24,000
Total >=200%	62,000	18,000	80,000

public option plan is not estimated in this analysis, but could be relatively significant.

A smaller number of individuals would enroll in a Platinum public option plan because the price differentials between the current lowest Platinum plan and a public option are proportionally smaller than for Gold plans. Using the moderate price elasticity scenario, an estimated 58,000 individuals (45,000 previously uninsured and 13,000 from off-Marketplace plans) would enroll in a Platinum public option plan. Two-thirds (38,000) are estimated to have incomes between 200 percent and 400 percent of the FPL and be eligible for federal subsidies. The number of people who previously had QHP coverage switching to the new Platinum public option plan is not estimated in this analysis, but could be relatively significant.

New York State would not bear any direct program costs associated with offering a Gold or Platinum public option plan and any additional administrative costs would be relatively modest. The federal government would bear the cost of APTCs for newly enrolled beneficiaries. For the Gold public option plan, additional APTCs are

estimated to cost \$214 million in the moderate take-up scenario. New York State would collect about \$9 million in additional HCRA tax revenue associated with newly insured individuals, and provider uncompensated care costs would be an estimated \$73 million lower. For the Platinum public option plan, additional APTCs are estimated to cost \$145 million in the moderate take-up scenario. New York State would collect about \$6 million in additional HCRA tax revenue associated with newly insured individuals, and provider uncompensated care costs would be an estimated \$53 million lower.

Several secondary impacts are likely associated with implementation of the public option plan. First, the lower provider reimbursement rates would reduce revenue for providers serving individuals who previously were covered in other QHPs. However, providers would benefit from the newly-insured using services and the reduction in uncompensated care costs. In the Gold public option, an estimated 18,000 individuals would switch from off-Marketplace coverage; in the Platinum public option, 13,000 individuals make this change. (See Table 12.)

Table 12: Number of People Enrolling in Platinum Public Option Plan (Moderate Take-Up Scenario)

Income (FPL Range)	Previously Uninsured	Off-Marketplace Moving to On-Marketplace QHPs	Total
200-400%	31,000	7,000	38,000
>=400%	14,000	6,000	20,000
Total >=200%	45,000	13,000	58,000

Additional individuals (not estimated in this analysis) may switch from other QHPs to the new public option plans. The magnitude of this revenue loss is not estimated but could be substantial, and more challenging for safety net providers that do not have a significant portion of revenues from commercially insured patients. Policymakers should consider this and the stability of the safety net system when choosing a public option's design parameters.

Second, plans' revenues would be lower for serving individuals changing coverage because of the increase in MLRs. This also could be relatively substantial for some insurers and should be considered by policymakers. However, plans also would benefit from greater overall enrollment, as thousands of currently uninsured individuals are estimated to gain coverage.

Third, some additional current Marketplace QHP enrollees would switch from other plans to the public option plan. This would be unlikely to directly impact State or federal spending, though there could be some impacts if higher income enrollees switch from lower metal tiers to the Gold or Platinum public option. Specifically, shifting enrollment in the Silver tier market would affect the calculation of APTCs and EP premiums. These dynamics are not currently modeled.

Savings are calculated based on State subsidized plan premiums estimated to be 25 percent lower than current lowest average QHP premiums in each metal tier because

“A public option, which would reduce health plan overhead and provider rates...would have significant effects on all and particularly safety-net providers, insurers, and the state health care environment.”

of the differential in provider reimbursement rates. It is possible that State subsidized plan premiums would be lower than this estimate because of selection impacts. However, these effects are likely to be modest and are not modeled here.⁷⁰

A public option, which would reduce health plan overhead and provider rates and create a plan essentially equivalent to others but at a lower cost, would have significant effects on all and particularly safety net providers, insurers, and the state health care environment. These effects would vary depending on how the public option ultimately is designed and implemented. The impacts of individuals switching health plans and effects on provider and plan revenues, the safety net system's stability, and health care utilization have not been modeled here but should be considered closely if State policymakers want to explore this strategy.

STRATEGY 4: STATE PROGRAM FOR LOW-INCOME IMMIGRANTS

Summary of Findings: A New York State-funded program designed to cover uninsured immigrants whose immigration status currently bars them from enrolling in coverage would help narrow the coverage gap faced by low-income immigrants. This program would offer a State-funded EP benefit package to immigrants with incomes below 200 percent of the FPL on a voluntary basis.

This option would insure 46,000 immigrants using moderate enrollment assumptions. The program’s gross State cost would be \$665 million annually. However, the program’s new, incremental State cost would be \$345 million, with an offset of \$316 million related to existing federal and State support for the Emergency Medicaid program now serving immigrants were applied to the new program. The incremental State cost per newly covered person would be \$7,600 in the moderate take-up scenario, assuming the Emergency Medicaid offset. Provider uncompensated care costs would be reduced by approximately \$18 million.

Background

Immigrants constitute the third largest group of uninsured New Yorkers. Many immigrants obtain private coverage through their employer, family members, or in the individual market. Nonetheless, native-born New Yorkers have an uninsured rate of 4 percent compared to 21 percent for noncitizens.⁷¹ Like their citizen counterparts, low-income immigrants are more

likely to be uninsured than moderate- or high-income immigrants. (See Appendix C.) But low-income immigrants have fewer coverage options than other low-income residents because of real and perceived eligibility restrictions related to immigration status.

Census data indicate that there are approximately 700,000 “unauthorized” immigrants in New York State.⁷² As described below, “unauthorized” includes immigrants with both lawful and unlawful status. Some

Table 13: Immigrant Coverage Program Impact Summary (Moderate Scenario)

Total Eligible below 200% of FPL	245,000
Uninsured Eligible	154,000
Total Beneficiaries	46,000
Beneficiaries Gaining Insurance Coverage	46,000
Total Direct Program Costs	\$665,000,000
- Emergency Medicaid Spending	\$316,000,000
- Additional HCRA Tax Revenue	\$4,000,000
- Net New State Program Cost	\$345,000,000
Net New State Program Cost per Beneficiary Gaining Coverage	\$7,600
Hospital Uncompensated Care Savings	\$19,000,000

unauthorized immigrants are legally precluded from enrolling in insurance programs open to other New Yorkers. Other eligible immigrants can be reluctant to enroll in insurance programs for fear of jeopardizing their status. Immigration status and income interact to produce large disparities in coverage rates—60 percent of the undocumented immigrant population (unauthorized immigrants without lawful status) are uninsured.

The population of immigrants below 200 percent of FPL who are currently ineligible for coverage is an estimated 245,000 people (of which 154,000 are uninsured). Generating this estimate of the number of uninsured immigrants is challenging because of the complex public insurance program eligibility rules and the limited data on immigration status. For the purposes of modeling this coverage strategy, there is an important distinction in public insurance eligibility rules between: (1) immigrants who have one of a set of immigration statuses (collectively known as people who are Permanently Residing Under the Color of Law, or PRUCOL) that bars their eligibility for federally-funded coverage; and (2) immigrants without any status, sometimes referred to as “undocumented” who are also ineligible for publicly-funded comprehensive coverage.⁷³ People with a PRUCOL status are lawfully present, known to the government, and historically have been safe from deportation. While being in either category precludes access to public insurance programs in most states, New York extends eligibility for Medicaid (without the use of federal funds) to many immigrants with PRUCOL status.⁷⁴

Design Considerations

The key design features of a State program for immigrants are: the scope of benefits and premiums, the eligibility criteria, and the enrollment processes. These design features were selected to build on the success of the EP program, which already serves many of New York’s lawfully present immigrants, and to conform to legislative proposals supported by immigrant advocates and introduced in the two latest legislative sessions.⁷⁵

Scope of benefits.

A 2016 report by the Community Service Society presented three possible design options for covering immigrants at the state level: (1) a program that offers coverage to adult immigrants with incomes up to 200 percent of the federal poverty level; (2) a young adult option; and (3) a Bronze plan option for low-income immigrants.⁷⁶ In 2019, California enacted a program similar to the second option which makes undocumented low-income young adults (under the age of 26) eligible for a state-funded Medicaid program. In 2020, Illinois expanded its Medicaid program to undocumented seniors.

The strategy modeled for this report updates the first option proposed by the Community Service Society to offer a New York State-funded EP to immigrant adults with incomes below 200 percent of FPL. As discussed above, EP covers citizens and some unauthorized PRUCOL immigrants. This strategy would extend this coverage to other immigrants who meet the income requirements but are ineligible because of their legal status.

Eligibility criteria.

About 154,000 uninsured New Yorkers would be eligible for this program based on their income and immigration status. The estimated 154,000 uninsured eligible people is a notable decline from the 240,000 people estimated to be eligible for a similar program in the 2016 Community Service Society study.⁷⁷ The decline is largely because of four factors. First, the available Census data indicates that fewer non-citizens overall live in New York today than at the time of the previous study.⁷⁸ Second, more unauthorized immigrants are estimated to have PRUCOL status than in the original study, indicating that a smaller share of unauthorized immigrants are undocumented than previously estimated.⁷⁹ This pattern was revealed by analyzing actual EP enrollment numbers for PRUCOL immigrants, which did not exist at the time the original study was conducted. Third, research indicates that nationwide, fewer undocumented immigrants are now uninsured, because more immigrants have access to employer-sponsored insurance coverage.⁸⁰

Finally, federal policy changes since 2017 have significantly undermined public program enrollment amongst immigrants.⁸¹ In February 2017, a heavily publicized draft Presidential Executive Order described the intention to promulgate a “public charge” rule that would restrict future eligibility for Lawful Permanent Resident Status (often called a Green Card) if the immigrant had used certain public programs.⁸² As a result, immigrant participation in a variety of public programs decreased precipitously.⁸³ A similar decline in immigrant enrollment in government health insurance was documented in the wake of the 1996 welfare reform law that

“Many immigrants obtain private coverage through their employer, family members, or in the individual market. Nonetheless, native-born New Yorkers have an uninsured rate of 4 percent compared to 21 percent for noncitizens.”

restricted immigrant participation in public assistance.⁸⁴ The final “public charge” regulation was issued in 2019 and was quickly stayed by the courts. It exempted the use of Emergency Medicaid (described below), the EP, Child Health Plus, and Marketplace subsidies. The public charge rule was vacated in March 2021 under the Biden Administration. However, misunderstanding about this and fear that a future Administration could re-enact such a rule may have long-term effects.

Enrollment processes.

Because of immigrants’ lingering concerns about the potential effect on their future ability to adjust their immigration status, enrollment into the new EP program for immigrants would be on an “opt in” basis and not automatically connected to the use of Emergency Medicaid. While automatic enrollment at the time a patient or provider seeks Emergency Medicaid benefits would increase participation in the program, it may not be a feasible option to consider in the current policy environment. Higher participation among former Emergency Medicaid users is assumed.

Changes in Insurance Coverage and Fiscal Effects

An estimated 154,000 uninsured immigrants would become newly eligible for a State-funded EP in 2023. Two groups would be newly eligible: (1) immigrants who utilize the State’s Emergency Medicaid program; and (2) immigrants whose income is below 200 percent of the federal poverty level and have not historically used Emergency Medicaid paid services. These two groups would have different take-up rates and their cost profiles would be different, because of differences in their health/risk profiles.

The first group is drawn from the people who use Emergency Medicaid. The Emergency Medicaid program pays for certain services received by immigrants who do not have a lawful immigration status, whose incomes are below 138 percent of the federal poverty level, and who have a certified emergency condition, cancer, or end stage renal disease. It is not comprehensive insurance and does not cover routine doctor visits or regular medical care. Based on the most recent data available (2017), about 74,000 undocumented immigrants are estimated to use this program in 2023.⁸⁵

Immigrants who use Emergency Medicaid are likely to enroll in the new EP program at higher rates than immigrants who do not, because they have a connection to the health care system and are more likely to have significant medical needs. Between 30 percent and 50 percent of the Emergency Medicaid users are projected to enroll in the new program, with a moderate take-up rate of 40 percent or about 30,000 of the 74,000. (See Table 14.)

The second group is 80,000 potential new enrollees with incomes up to 200 percent of the FPL who have not previously used Emergency Medicaid services. These include those with incomes below 138 percent of the FPL who would have previously been eligible but not utilized Emergency Medicaid services, and those with incomes from 138 to 200 percent of the FPL who would not have been eligible for Emergency Medicaid services. Since they could have utilized Emergency Medicaid if they had intensive medical needs, those who were eligible but did not use Emergency Medicaid services are likely healthier than those who used Emergency Medicaid. Those ineligible for Emergency Medicaid with

Table 14: Immigrant Essential Plan Program Eligible and Expected Take Up (2023)

Uninsured Immigrant Adult Subgroups Newly Eligible for Essential Plan Coverage	Total Eligible	New Essential Plan Enrollment (Moderate Take-Up Scenario)
Emergency Medicaid Users	74,000	30,000 (40%)
Non Emergency Medicaid Users with incomes below 200% of FPL	80,000	16,000 (20%)
Total Immigrants Newly Eligible for Essential Plan Coverage	154,000	46,000 (30%)

incomes above 138 percent of the FPL include a mix of higher and lower risk individuals. Among this entire group, between 10 percent and 30 percent are projected to enroll with a moderate take-up rate of 20 percent, or 16,000.

Estimating the cost of the new EP option requires three steps. The first step is to estimate the per member per month (PMPM) premium cost, which involves modifying the current EP premium using morbidity adjustments based on the health status of the three groups likely to enroll. The second step is to calculate the gross cost of the program for the population estimated to take up. The final step is to estimate offsets to the gross costs including: the cost of Emergency Medicaid benefits for the enrollees; the premiums to be paid by the higher income enrollees; and the HCRA taxes likely to be collected.

The average EP premium in 2021 is \$426 in New York City and \$396 for the rest of the State. Assuming 75 percent of eligible immigrants live in New York City (a higher proportion than the current EP population), a blended premium rate of \$414 is used to estimate program costs. Projected forward to 2023, the statewide average premium would be \$432. The 2023 medical claims cost (including all medical and pharmacy costs) is estimated to be \$373, or about 85 percent of the average total premium.⁸⁶ Applying morbidity adjustments for each population, as detailed in the methodology Appendix, the estimated gross PMPM of \$1,218 in the moderate take-up scenario, largely as a result of the enrollment of Emergency Medicaid users

“An estimated 154,000 uninsured immigrants would become newly eligible for a State-funded Essential Plan in 2023.”

who have a high-risk profile. Accordingly, the total gross costs of the program in a moderate take up scenario would be \$665 million to cover 46,000 enrollees, which would represent both the cost of current Emergency Medicaid services delivered to immigrants enrolling in the program as well as new program costs to New York State.

New York could design the new immigrant EP program so that the benefit would supplement or “wrap around” the Emergency Medicaid program for enrollees whose incomes are below 138 percent of the FPL and utilize services that would be paid by Emergency Medicaid. The State would pay 100 percent of costs for enrollees with incomes between 139 percent and 200 percent of FPL. For individuals with incomes below the Medicaid threshold of 138 percent of FPL, the insurance companies would submit claims eligible for Emergency Medicaid to the State in order to secure federal matching funds. Ideally, this funding mechanism would be coordinated with federal officials and invisible to the individual enrollee. The offset for the federal and State current spending on Emergency Medicaid for immigrants

enrolling in the new EP is estimated to be \$316 million in the moderate take-up scenario. This represents roughly 75 percent of the total cost of care for the 30,000 Emergency Medicaid users who are estimated to enroll in this new immigrant EP program in the moderate scenario. This estimate is supported by information provided by the New York Department of Health indicating that the total Emergency Medicaid program cost was \$685 million in 2017.⁸⁷

The State would also collect additional HCRA tax revenue associated with the care of this population. However, this revenue is estimated to be \$4 million annually, a relatively modest amount when compared to the other strategies analyzed, because the historic Emergency Medicaid users previously had most of their hospital care paid by Emergency Medicaid dollars which were already subject to HCRA surcharges.

After these offsets are applied, in the moderate take-up scenario the net new State program cost would be \$345 million annually or about \$7,600 per newly insured person, or \$633 PMPM. The program would cover an additional 46,000 New York immigrant residents.

Additionally, with newly eligible individuals gaining coverage, annual uncompensated care costs to hospitals are estimated to be \$19 million lower.

Table 15: Summary of Impacts

Total Costs and Cost Offsets	Moderate Take-Up Scenario
ER Medicaid Enrollees	30,000
Non ER Medicaid Users <150% FPL	16,000
Total Enrollees	46,000
Total PMPM Cost (including ER Medicaid Services)	\$1,200
Total PMPY Cost (including ER Medicaid Services)	\$15,000
Total Gross Annual Program Cost	\$665,000,000
Less:	
Emergency Medicaid offset (State + federal ER Medicaid costs)	\$316,000,000
Additional HCRA Revenue (excl Emergency Medicaid users)	\$4,000,000
Total Annual Program Cost Net of Offsets	\$345,000,000
Total State Program Cost	\$345,000,000
Total New Federal Program Cost	\$0
Net Annual State Cost per Newly Insured	\$7,600
Uncompensated Care Reduction	\$19,000,000

STRATEGY #5: ENHANCED OUTREACH AND ENROLLMENT STRATEGIES

Summary of Findings: This section analyzes three options to increase coverage among people eligible for, but not enrolled in, subsidized coverage.⁸⁸ These strategies would reach those who are unaware of their eligibility or who have been unable or unwilling to sign up for coverage. They do not enhance cost-sharing or expand eligibility, but encourage uninsured people to enroll in existing coverage programs.

The first option would expand the existing Navigator program. It would enroll an estimated 65,000 people at an incremental expand administrative State cost of \$300 each or \$20 million in total annually. The second option is a new program to permit uninsured people to start the process of signing up for insurance enrollment through their tax returns; this would result in an estimated 10,000 additional individuals enrolling in public or Marketplace coverage with minimal new administrative implementation costs, which have not been estimated. The third option would permit new exceptions to the limited

open enrollment period for Marketplace enrollees; data limitations preclude estimates of the added coverage and costs for this option.

While these options would not change existing programs' benefits or eligibility, enrollment of additional previously eligible but not enrolled individuals would increase the costs of the existing programs. For example, when an individual who is eligible but not enrolled in the Medicaid program does enroll, the State's costs for Medicaid coverage increase. These incremental program costs because of higher enrollment in existing programs are not modeled in this report.

Background

Roughly 345,000 uninsured New Yorkers are eligible for free or low-cost coverage through Medicaid, Child Health Plus, or the Essential Plan. Another 259,000 uninsured New Yorkers are eligible for tax credits to offset the cost of individual market premiums. Premiums may still be high relative to income for some people in this category, but some may be eligible for Marketplace coverage for a small fraction of their income or with no premiums. For these New Yorkers, the primary barrier to health

Table 16: State Premium Assistance Program Impact Summary (Moderate Estimates)

Impact	Option 1: Expanded Navigator Program	Option 2: Tax Filing Outreach	Option 3: Open Enrollment
Newly Insured	65,000	10,000	Not modeled
Total Net State Cost	\$20,000,000	Nominal	Not modeled
Net State Cost per Newly Insured	\$300	Nominal	Not modeled

insurance may be a combination of limited knowledge of options and difficulty navigating the eligibility and enrollment process rather than price.⁸⁹

New York could pursue three options to increase enrollment among uninsured people eligible for free or low-cost coverage: (1) expand the Navigator program to enhance outreach in communities with high numbers of uninsured people; (2) use tax returns to assess eligibility and help or automatically enroll people in no-cost coverage; and (3) allow year-round enrollment in QHPs for Marketplace enrollees.

Option 1. Expand the Navigator program, targeting communities with high numbers of uninsured people.

New York's Marketplace provides a streamlined eligibility and enrollment process to conduct real-time eligibility determinations and enrollment into Medicaid, the EP, and QHPs with or without subsidies. Nonetheless, many New Yorkers remained deterred by the online Marketplace website, including issues with: proving identity; calculating income; establishing household composition; and the health plan selection process.

In-person outreach and enrollment assistance has been a crucial strategy for states that have been the most successful at reducing the number of uninsured residents since the implementation of the ACA.⁹⁰ New York was a pioneer in providing public coverage enrollment assistance, and its facilitated enrollment programs (precursors to the current Navigator program) served as a model for many states.⁹¹

In 2013, New York launched its ACA Navigator program that serves every county. Navigators are State-certified enrollment counselors that provide free unbiased enrollment assistance. Navigators help individuals: set up a Marketplace account; verify their identities; establish their household composition; assist them with validating their income in order to assess their eligibility for public coverage or financial assistance; and walk them through their providers, pharmacy needs, and health plan options. The program is predominately run through nonprofit community-based organizations that provide culturally and linguistically competent services, although a few providers organizations also are certified as Navigators. Navigators are trained and certified by the Marketplace and must comply with annual recertification training requirements. Roughly 70 percent of Marketplace enrollees utilize in-person assistance of some kind, and more than 417,000 people currently enrolled used the NYSOH Navigators.⁹²

Navigator organizations receive grants from the State and are distinct from other types of assisters—brokers and certified application counselors—that typically receive compensation from either an insurance company or a health care provider.

The availability of in-person assistance provided by local organizations is an essential component of the Navigator program. For example, during recent focus groups, Western and Central New Yorkers said that access to local, in-person assistance had made a big difference in their ability to obtain coverage, and that additional “education and outreach would help uninsured

connect with health benefits.”⁹³ The State’s largest Navigator program indicates that the average cost per enrollment is \$100, and in the past, Navigators enrolled 2.5 times more people per full-time equivalent than the other assister models.⁹⁵

Since New York already has relatively high public insurance take-up rates, the remaining uninsured are likely harder to find and enroll than those already enrolled. As a result, the average enrollment cost to reach the remaining uninsured would likely be higher than the \$100 average cited above. Analysis of cost and enrollment data for the most cost-intensive insurance enrollment program (the Facilitated Enrollment for the Aged, Blind, and Disabled Medicaid program) indicates that it costs on average \$300 per enrollment.⁹⁶

A suitable near-term goal for an expanded Navigator program would be to reduce the rate

of uninsurance in counties with high numbers of uninsured to a rate that is closer to the Statewide or regional average. The target population for narrowing the uninsurance rates is those with incomes below 400 percent of the FPL because they are already eligible for free or low-cost health insurance or for subsidies to purchase a QHP.

Design Considerations

The uninsured population with incomes under 400 percent of FPL is about 821,000 statewide. (See Table 17.) More than half of New York’s uninsured people live in New York City. Roughly 25 percent of the uninsured below 400 percent of FPL are ineligible to enroll in public or Marketplace coverage because of their immigration status (and disproportionately reside in the New York City metropolitan area). Even omitting ineligible immigrant residents, the five boroughs make up more than half of the state’s uninsured population below 400 percent of the FPL.

Table 17: Percent of Uninsured New Yorkers Living in New York City, ROS and Statewide, 2019 ⁹⁷

County	Number of Uninsured People	Share of NYS’s Uninsured Population	Number of Uninsured People Under 400% FPL	Share of NYS Uninsured Population Under 400% FPL	Uninsured Eligibles Under 400% FPL	Share of Uninsured Eligibles Under 400% FPL
Bronx	111,000	11%	99,000	12%	68,000	11%
Kings	159,000	16%	126,000	15%	85,000	14%
New York	72,000	7%	59,000	7%	42,000	7%
Queens	209,000	21%	170,000	21%	104,000	17%
Staten Island	19,000	2%	16,000	2%	11,000	2%
Total NYC	570,000	56%	469,000	57%	308,000	50%
Total Rest of State	442,000	44%	352,000	43%	303,000	49%
Total Statewide	1,012,000	100%	821,000	100%	611,000	100%

Statewide, an estimated 5.4 percent of individuals earning below 400 percent FPL who are eligible to participate in public coverage or purchase Marketplace coverage are uninsured. The uninsurance rate for this group is disproportionately high in New York City—6.0 percent compared to the 4.8 percent in the rest of the State. (See Table 18.)

A program to expand the Navigator program to target high uninsured locations would direct resources so that the boroughs in New York City could achieve eligible uninsured rates equal to the statewide average (reducing 6.0 percent to 5.4 percent), and counties outside the City could achieve the rest of state regional average (reducing to 4.8 percent).

Table 18: Eligible Uninsured Earning Below 400% FPL by County, High Uninsurance Counties, 2019 ⁹⁸

County	# of Eligible Uninsured People Earning Below 400% FPL	Uninsurance Rate for Eligible Population Earning Under 400% FPL
Queens	104,000	7.0%
Bronx	68,000	6.1%
Dutchess	8,000	6.8%
Oneida	8,000	5.7%
St. Lawrence	7,000	10.3%
Chautauqua	6,000	7.0%
Cattaraugus	5,000	10.1%
Oswego	5,000	6.4%
Jefferson	4,000	5.9%
Steuben	4,000	6.4%

Changes in Insurance Coverage and Fiscal Effects

Expanding the Navigator program has the potential to enroll an additional 65,000 individuals in New York City and target counties in the rest of the state with higher-than-average uninsurance rates. The cost of this program would be minimal, with average administrative cost of between \$100 and \$300 per enrollee, exclusive of new costs related to increased enrollment of individuals with existing program eligibility.

Option 2: Use tax returns to assess eligibility and provide an option for automatic enrollment in no-cost coverage

New York could follow the lead of Maryland and integrate the processes of filing for taxes and enrolling in health coverage programs.

In 2020, Maryland implemented its Maryland Easy Enrollment Health Insurance Program that allows residents to check a box on their income tax returns to trigger an eligibility check for health insurance.⁹⁹ Checking the box sends income information to the state’s Marketplace. If the resident is eligible for Medicaid or CHP, the State sends an invitation to select a plan. The resident is enrolled automatically into a default option if no choice is made within a certain time frame. For people with higher incomes, checking the box triggers a special enrollment period that allows them to purchase individual Marketplace plans. Some State funding would be used to pay tax preparers for enrolling clients in coverage.

Design Considerations

The Maryland model eliminates significant administrative barriers for uninsured individual by auto-enrolling them into free coverage and provides a second chance to enroll for people who missed open enrollment. New York would have to decide whether to use tax preparers as enrollers or to use this process to direct uninsured New Yorkers towards existing enrollment assistors. The Maryland model also ensures that immigrants concerned about the possible adverse consequences that the use of health coverage may have on their plans to adjust their immigration status to bypass the system since individuals must proactively check the box on their tax filings.

One important limitation is that this strategy will not identify the many New Yorkers who qualify for Medicaid, CHP, or the Essential Plan but do not file income taxes. The 2021 tax filing threshold is \$12,400 for single people under the age of 65 and \$24,800 for married couples. Many people below that threshold who would qualify for free health coverage would not be identifiable through tax returns because they do not file taxes. However, the option is worth exploring since many uninsured tax filers might wish to take advantage of a simple check box to start the enrollment process.

Changes in Insurance Coverage and Fiscal Effects

Recent reporting by the Maryland Health Benefit Exchange provides a basis to estimate the coverage impact if this program were implemented in NYS.¹⁰⁰ In Maryland, during the first year of implementation of the program, roughly 2 percent of all tax filers took the initial step to check a box on their state income tax form to receive information about enrolling in coverage. Ultimately, the program produced a 3 percent estimated increase in coverage among estimated Medicaid/CHP-eligible uninsured, and a 0.5 percent estimated increase in coverage among estimated APTC-eligible uninsured.¹⁰¹

If this program were implemented in New York State, an estimated 10,000 uninsured residents with incomes below 400 percent of FPL would enroll in coverage: 8,000 new Medicaid/CHP enrollees and 2,000 EP or subsidized QHP enrollees. (See Table 19.)

This option would have incremental costs for administration and for the new coverage. The NYSOH website already integrates with federal tax information to assist with enrollments, but it does not integrate information from State

Table 19: Estimated NYS Take-up Under Tax Return Based Enrollment Option (Maryland Model)

	Newly Covered Population (previously uninsured eligibles)	% of Current Uninsured Newly Enrolled
Medicaid/CHP <138% FPL	8,000	2.9%
EP/Subsidized QHP 138-400% FPL	2,000	0.5%
Total	10,000	1.9%

tax filings. An electronic process would have to be developed to allow timely communications between the State's tax infrastructure and the NYSOH. If New York decided to reimburse tax preparers and other new enrollment assistors, there would be additional new costs associated with these grants. These new administrative costs may be relatively modest and are not estimated more precisely in this report. Similarly, increased program costs of expanded enrollment of eligible individuals are not estimated here.

Option 3: Provide opportunities for people to enroll in Qualified Health Plans outside of open enrollment.

Open enrollment periods limit the time during which people can purchase insurance. Without this limitation, some people might strategically avoid paying premiums until they know they will use the coverage. The more people who do this, the more premiums increase because of adverse selection. However, people miss open enrollment deadlines for reasons other than a desire to avoid paying premiums. Open enrollment occurs at the end of the year—a time when many people are most financially stressed and preoccupied with the holidays. Moreover, some people may not know about open enrollment periods or may be unaware that there are open enrollment periods for Marketplace plans.¹⁰²

States that run their own Marketplaces, as New York does, have control over the length of open enrollment. In states that have federally-facilitated Marketplaces, the length of open enrollment is set by the federal Department of Health and Human Services (HHS). Over the past two years, HHS has shortened open enrollment for those Marketplaces to 45 days, while states like New York have maintained open enrollment periods of three months. This likely has contributed to New York's success in enrolling people during a time of generally decreasing insurance coverage in the rest of the country.¹⁰³

States that run their own Marketplaces can also add exceptions to open enrollment periods for changes in individual circumstances that change coverage needs. For example, New York is the only state that offers a special enrollment period for pregnancy. Other special enrollment periods open because of job changes or job loss, moves, or changes in marital status. For much of the COVID-19 pandemic, New York has essentially maintained year-round open enrollment. There is no evidence of adverse selection because of these special enrollment periods thus far.

Design Considerations

Despite New York's efforts, many people still fail to enroll during open enrollment or during a qualifying special enrollment period. In addition, many New Yorkers lose coverage outside of open enrollment and then cannot

reenroll in coverage. A common example of this occurs when there are auto-bill errors or other payment snafus. New York could explore adding additional open enrollment exceptions to help people who want to purchase (or maintain) health insurance outside of open enrollment.

In Massachusetts people who are purchasing insurance through the Marketplace for the first time, earn up to 300 percent of the FPL, and are otherwise eligible for federal premium subsidies may enroll outside of open enrollment.¹⁰⁴ Others may apply for an open enrollment waiver by testifying that they did not intentionally forgo insurance during open enrollment or that they lost coverage and were unaware until after the 60-day special enrollment period had elapsed.¹⁰⁵ In Massachusetts, the number of people in the individual market increases instead of declines throughout the year because of these options.¹⁰⁶

New York could implement a similar set of policies to those in Massachusetts. In addition, New York could consider a higher income cutoff (or no cutoff) for access to these options, although further loosening any of the restrictions that exist in Massachusetts may increase the likelihood of adverse selection and premium increases. Still, implementing some of this report's other strategies would increase enrollment and reduce population risk in the Marketplace, which may reduce the risk of adverse selection associated with adding exceptions to the open enrollment period.

“Despite New York’s efforts, many people still fail to enroll during open enrollment or during a qualifying special enrollment period. In addition, many New Yorkers lose coverage outside of open enrollment and then cannot reenroll in coverage.”

Changes in Insurance Coverage and Fiscal Effects

Administrative costs to implement the open enrollment modifications would be modest. New York maintains its enrollment infrastructure year-round already to accommodate people with special enrollment periods. Since good evidence to estimate the number of people who might add coverage under this option is not available, no estimates are made in this report of the number of newly covered or the cost of that new coverage.

APPENDIX A – BASELINE POPULATION ESTIMATE SUMMARIES AND POLICY OPTION IMPACT MODELS

The population coverage and cost effects of the proposals described in this report were generated by CBC and CSS, utilizing multiple primary data sources, modeling inputs and methods. At a high level, the modeling effort included the following components:

1. Baseline Population Profile by Coverage, Age, Income, and Detailed Immigration Status
2. Estimated Effects of Policy Proposals in 2023

Baseline Population Profile by Coverage, Age, Income, and Detailed Immigration Status

This section describes the data sources and methodological approach used to produce a 2023 population profile with the segmentation required to appropriately model the enrollment and cost effects of the policy proposals discussed in the paper.

2019 Baseline Population Profile

The baseline data used for all of the population analyses in the study is drawn from the 2019 American Community Survey (ACS) Public Use Microdata Sample (PUMS).¹⁰⁷ The 2019 ACS PUMS dataset used for this project was obtained from IPUMS, a project of the Minnesota Population Center at the University of Minnesota.¹⁰⁸ A five-year ACS blend (2015-2019) was also used as a point of reference providing a larger sample size to evaluate the

values derives from the one-year 2019 data for small cells.

The ACS PUMS data enables preliminary segmentation of the sampled population by four key dimensions of interest.

- Age Group – Child age 0-18, non-elderly adult age 19-64, and elderly adult age 65 and older.
- Income Level – For health insurance coverage program eligibility assessment, SHADAC Health Insurance Unit and Federal Poverty Guideline (Health Insurance Unit/Federal Poverty Guideline (HIU/FPG)) method was used in lieu of Census provided Federal Poverty Level (FPL) ratios.¹⁰⁹
- Health Insurance Coverage Type – Individuals were assigned hierarchically to a unique coverage category as observed on the coverage variables in the ACS, consistent with the method used by the Kaiser Family Foundation.¹¹⁰ Multiple administrative data sources were used in addition to the ACS PUMS data to validate and provide additional detailed segmentation of baseline coverage in key segments (most notably the Essential Plan (EP), on-Marketplace Qualified Health Plan (QHP) and the off-Marketplace individual market) in New York State (NYS).¹¹¹ The methods and data sources used for coverage mix estimates are described in greater detail in Appendix B.
- Immigration Status – ACS provides a basic citizenship variable (citizen/non-citizen). Additional detailed immigration status of non-citizens was further segmented into categories applicable to public health insurance eligibility assessment –

authorized non-citizens, non-citizens who are permanently residing under color of law (PRUCOL), and undocumented non-citizens. The methods and data sources used to segment these detailed immigration status groups are described in greater detail in Appendix C.

Projection of 2019 Baseline Population Profile to 2023 Baseline (No Intervention Scenario)

The COVID-19 pandemic and associated recession caused significant shifts in health coverage enrollment, especially from ESI to Medicaid or EP. Given the continued uncertainty about the trajectory of employment and economic recovery, as well as state and federal policy, this analysis assumes that the population and coverage mix in 2023 will be the same as in 2019. The effects of policy options are estimated from that starting point.

Estimated Effects of the Policy Proposals in 2023

The population, costs, and other financial impacts associated with each of the identified policy proposals and options discussed in this report was modeled as a change to the 2023 projected baseline population (i.e., estimating how coverage and costs would be different under this policy, compared to a scenario where the state does not implement any policy changes in 2023). Each policy proposal is modeled distinct of any other of the proposal(s) discussed in this paper.

For each proposal/option, a range of effect estimates were modeled, representing a likely low, moderate, and high effect profile. As described below, estimating the potential coverage and cost effects of each proposal

required a distinct approach to the following general methodology:

- Identify the potentially eligible population targeted by the proposal, as subgroup(s) of the 2023 projected baseline population using the segmentation described above.
- Estimate the number of people who are likely to benefit from the proposal, either by gaining new coverage (take-up) or receiving enriched benefits associated with existing coverage. In most cases the population was segmented into different baseline eligibility groups which face different circumstances and likely will exhibit different take-up behaviors. We assume that existing protections and requirements excluding individuals with access to employer-sponsored insurance (ESI) from enrolling in QHPs would continue to apply – as such, models do not assume any crowd-out of ESI associated with these proposals.
- Calculate the direct program cost, state cost, and federal cost of providing the benefits to the population(s) projected to receive benefits, net of direct offsets (for example, the Emergency Medicaid funding available to offset the total medical costs of some undocumented immigrants, or new state tax revenue associated with a state individual mandate). Costs were typically modeled for each identified population subgroup. For purposes of calculating Advanced Premium Tax Credits (APTCs) and baseline premium costs associated with each proposal, The projected 2023 EP and QHP benchmark (second-lowest silver plan) rates were calculated based on

published 2021 statewide average rates and 2019-2021 observed premium trends for each program.¹¹² Additional adjustments to these rates for population morbidity and other factors were implemented for some programs, as applicable. Costs and APTCs were calculated based on the statewide average individual premium regardless of enrollee age. For example, for policies that were projected to increase enrollment among children, the cost of the child enrollees would be overstated, yielding conservative estimates of cost (though the overall effect is marginal given the relatively small number of children effected by the identified proposals). Only new costs attributed to new eligibility (for coverage or benefits) as provided in the policy proposal were included in cost estimates.

- Identify the value of “below the line” cost/revenue offsets associated with the proposal, such as increased HCRA surcharge revenue (estimated at a net effective rate of 3.08 percent of total program cost for populations newly gaining coverage) and reductions in uncompensated care (estimated as a savings of \$1,174 per uninsured individual gaining coverage).¹¹³ In both cases, for the immigrant coverage model, individuals who historically utilized the Emergency Medicaid program were excluded for purposes of calculating these offsets.

Methodological elements of note specific to each proposal are described below.

State Individual Mandate and Penalty

We do not estimate any substantive coverage or fiscal effects of this proposal, as the repeal of

the federal mandate in 2019 had no measurable impact on coverage in New York State.¹¹⁴

State Premium Assistance Program

This program includes three potential new subsidy schedules, which provide enhanced premium assistance to the population eligible to purchase QHPs (federally eligible individuals) between 200 to 600 percent of FPL. Current QHP enrollees who are income eligible for premium assistance would receive these enhanced benefits with no change in behavior. In addition, a significant number of remaining uninsured individuals and some individuals currently enrolled in off-Marketplace coverage would be attracted to take up on-Marketplace QHPs, since this proposal would lower the relative cost of Marketplace coverage. This model assumes continuation of the current QHP enrollment rules with regard to ESI eligibility, and as such assumes no crowd-out of existing ESI coverage.

Take-up rates for each of the two groups entering the Marketplace (baseline uninsured and baseline off-Marketplace individual market enrollees) were calculated based on the percent reduction in average out-of-pocket premium costs after APTCs by income level, with a range of potential price elasticities of demand for health insurance coverage derived from the health economics research literature.¹¹⁵ A precise projection of the effect of providing richer premium subsidies on purchasing decisions is not possible to estimate. However, based on the available literature, CSS and CBC analyzed three price elasticity options (0.42 for low, 0.55 for moderate, and 0.75 for high) for people who are currently uninsured. In other words, for every 1 percent change in the effective price of the coverage available to an individual, there would be between a 0.42

percent and 0.75 percent change in their decision to purchase coverage.

For example, in subsidy Schedule 2, individuals between 200 percent to 250 percent of the FPL would experience a 60 percent decrease in their out-of-pocket cost to purchase coverage due to enhanced subsidies. In the moderate take-up scenario, this would yield a 33 percent take-up rate for this population ($0.60 * 0.55 = 0.33$). As noted above, to estimate the number of individuals who might move from off-Marketplace to on-Marketplace coverage we used the same methods but applied higher elasticity of demand factors, ranging from 0.75 to 1.25. Everyone who is currently enrolled in QHPs was then added to those estimates to capture the total number of people who would benefit. Take-up estimates are calculated based on the elasticity of demand factors and the projected change in costs under each premium assistance schedule relative to existing APTCs as defined by the ACA affordability schedule and estimated benchmark Silver premium in 2023.

The costs of the program were estimated to be the new state premium costs only, calculated by income level (FPL segment) for each of the subsidy schedule(s) proposed. These calculations utilize the average federal subsidy (APTC) available for that income group based on the 2023 projected statewide average benchmark premium (second-lowest cost silver plan), and the 2023 projected average individual income within the FPL segment, and the difference between the baseline average ACA premium requirements for each FPL segment and the proposed state premium assistance subsidy schedules. There were increased federal costs associated with beneficiaries newly enrolling in QHPs on the

Marketplace, new state costs for these individuals, and enhanced subsidies for current QHP enrollees.

No morbidity or selection effects are implemented in the premium assistance program model. It is possible that newly enrolling uninsured could be healthier than the existing QHP population, which could lead to a reduction in premium costs in QHPs in future years. To the extent that the benchmark Silver plan premium may be lower in the future when rates are adjusted to reflect the risk profile of these new beneficiaries, there may be some reduction in federal costs associated with APTCs, as well as a potential impact on the federal financing available for the Essential Plan.

State Public Option Plan

The public option program would provide lower cost Gold and/or Platinum QHP options on the Marketplace, with premium reductions coming from a mix of insurer MLR and provider reimbursement adjustments. There are many design options and additional analysis that would be required to define the specific features of procurement, rate setting, and implementation if New York State were to pursue this policy option that are not addressed in this paper.

For purposes of this paper, the potential premium cost of the new Gold and Platinum public option plans are estimated as a 25 percent reduction to the current lowest statewide average Gold and Platinum QHP rates. This would place the premiums in the new public option plans roughly at the midpoint between current QHP rates and current EP rates, adjusted for actuarial value. 2021 lowest average Gold and Platinum rates were estimated using multiple input data sources, and were then trended forward to 2023 using the observed average two-year trend.¹¹⁶

As for the premium assistance program, no morbidity or selection effects are implemented in the public option models, as the magnitude and directionality of these effects is unknown. It is likely that the population taking up public option plans would be somewhat healthier than the population in existing Gold and Platinum QHPs, which could be reflected in lower premium costs over time. Conversely, to the extent that existing Gold and Platinum QHP enrollees take up the new public option plans, the remaining risk pool in existing QHPs could experience increased risk selection, resulting in higher premiums in the rest of the individual market. If New York State were to pursue this policy option, these dynamics would need to be assessed as part of rate setting and procurement, and likely adjusted over time based on experience.

Take-up in the new Gold and Platinum public option plans is estimated using the same elasticity of demand approach and the same elasticity factors described above for the premium assistance program. Take-up is estimated for previously uninsured individuals, and enrollees moving from off-Marketplace coverage to Marketplace QHPs. The number of enrollees transitioning from current QHP coverage is not estimated, as state or federal APTC cost implications would be negligible for existing beneficiaries choosing the public option plans rather than existing QHPs (and any such effects would reflect reduction in federal costs for members who might receive less than the full value of APTCs for which they are eligible).

For purposes of this take-up analysis, elasticity factors are applied to the out-of-pocket premium cost difference between the average lowest Gold

and Platinum QHPs and the new public option Gold and Platinum plans that would be faced by consumers at each income level. Take-up was estimated for the Gold and Platinum options distinct from each other; if both options were offered, additional analysis would be required to identify the interaction and resulting take-up in each metal level.

The costs of this program are largely the cost of additional APTCs that would be paid by the federal government for new enrollees attracted to participate in the Marketplace as a result of the availability of the public option plan. The cost of these APTCs are estimated by income level of the projected new enrollees, following the standard ACA affordability schedule. New York State would bear some administrative costs associated with implementing the program, and could also experience a positive financial impact through increased HCRA tax revenue, so the financial impacts on New York State are nominal. Implications of the public option plan on other health system stakeholders (insurers, providers) are not estimated but could be significant and would need to be considered by policymakers if New York State were to pursue this policy option.

State Program for Low-Income Immigrants

This program would provide access to EP look-alike coverage for uninsured adult undocumented immigrants and a small additional population of PRUCOL immigrants who currently remain ineligible under State law (largely the Deferred Action to Childhood Arrivals or “DACA” immigrants) with income up to 200 percent FPL. Relative to the premium assistance model, this model assumes relatively

low take-up among all groups.¹¹⁷ Many immigrants face significant fear of participating in public health insurance programs, which was exacerbated by restrictive federal immigration policies, including the Public Charge rule which sought to limit immigrant participation in government-funded public health insurance. This analysis assumed a relatively high take-up among the estimated 74,000 individuals utilizing Emergency Medicaid benefits each year (who are already actively engaged with providers and the Medicaid program). It is important to note that this proposal assumes that enrollment would be fully voluntary (no administrative enrollment).

Unlike the premium assistance and public option proposals above, the immigrant coverage model includes selection adjustments. This is necessary for this proposal as there are known, significantly higher risk populations that would be represented among those taking up coverage (specifically, the population utilizing Emergency Medicaid benefits each year). Accounting for these higher risk groups in the estimate program costs yields more conservative results – to the extent that more healthy individuals do enroll than is currently estimated, the cost per enrollee could be substantially lower.

Premium costs for this policy proposal were based on EP premiums projected to 2023, with selection adjustments applied for each of the three populations with differential take-up assumptions. This portion of the model draws heavily on work performed by CSS in 2016, with the assistance of Gorman Actuarial, in establishing appropriate selection adjustments for the undocumented immigrant populations using (and not using) Emergency Medicaid.¹¹⁸

Briefly, for each population, it is assumed that the relative risk distribution matches the Federal Actuarial Value calculator, and that the sickest join first. So, for populations with low take-up rates, the overall selection factor will be greater than for populations with high take-up rates. And, among the population below 138 percent of FPL, it is assumed that the existing Emergency Medicaid users are the sickest, relative to other new eligibles who are not Emergency Medicaid users.

Based on the selection factors derived from this model, the cost of enrolling newly eligible immigrants would vary by the estimated level of take-up among the three sub-groups. For example, in the moderate take-up scenario a 3.1 morbidity factor is applied to the medical claims cost for the Emergency Medicaid users.¹¹⁹ In other words, the Emergency Medicaid users enrolling in the Essential Plan are likely to be 3.1 times sicker or more expensive than the current Essential Plan enrollees. Most of the second group (new enrollees below 138 percent of FPL) had access to Emergency Medicaid, but did not use it, and thus had a morbidity adjustment significantly below 1.¹²⁰ Finally, a 3.7 morbidity adjustment is applied to new enrollees above 138 percent of FPL, because many of these individuals likely would have had no access to coverage previously, and it is assumed that the sickest individuals among any newly eligible population would enroll first.

These morbidity adjustments are applied to the medical/pharmacy portion of the EP premium rate. In addition, an annual trend (based on historical experience) of 4.3 percent is added

Table A1: Essential Plan Rates with Adjustment Factors

	Moderate Take-Up Scenario
2021 Statewide Average EP 3/4 Rate, including Regional Adjustment	\$432
2021 Statewide Average Estimated EP 3/4 Medical Claims Costs (EP rate net of administrative and other non-medical costs)	\$373
Morbidity Adjustment / Selection – Emergency Medicaid Users	3.1
Morbidity Adjustment / Selection – Non-Users <138% FPL	0.2
Morbidity Adjustment / Selection – Non-Users 138-200% FPL	3.7
Blended Morbidity Adjustment	2.6
Estimated PMPM Medical Claims Costs	
Emergency Medicaid Users	\$1,154
Non-Emergency Medicaid Users	\$618
Total Medical Claims PMPM - Blend	\$966
Annual Trend Rate	4.3%
CY 2023 Estimated Medical Claims PMPM	\$1,050
CY 2023 Estimated Total Monthly PMPM	\$1,218

in order to calculate a 2023 blended monthly premium cost of approximately \$1,218 per member.

The major cost offset for this proposal relates to the existing Emergency Medicaid spending (state and federal) for this population. The most recent figure available from NYSDOH indicates that the total spending on this population was \$685 million in 2017,¹²¹ and previous analysis conducted by CSS in 2015 suggest that roughly three-quarters of the total medical costs for the population utilizing Emergency Medicaid would be paid by the existing Emergency Medicaid program once the population is enrolled in Essential Plan coverage.¹²² Combined with the take-up and selection estimates for the Emergency Medicaid utilizers, these datapoints yield a reasonable estimate of the Emergency Medicaid financing offset associated with this proposal at each take-up level (low/medium/high).

Enhanced Outreach and Enrollment – Expanded Navigator Program

This policy option estimates the opportunity to enroll additional individuals who are currently eligible for Medicaid and APTCs through additional investment in Navigator capacity in counties that have prevailing uninsurance rates above statewide and regional averages. There are many considerations about the targeting of additional resources that should be evaluated by policy makers, but the assumption underlying these estimates is that New York State can continue to engaged and enroll the remaining eligible uninsured with additional investment in targeted outreach and enrollment support.

The estimates of the opportunity to enroll uninsured individuals from higher uninsurance counties leverage data from the 2019 ACS, including both 2019 single year for larger

population counties and 2015-2019 five-year blend for smaller population counties. Since county level information is not available in the ACS PUMS, data was drawn from several pre-tabulated exhibits provided by the Census Bureau.¹²³ Several pre-tabulated exhibits were used to identify the number of uninsured below 400 percent of FPL, and then an adjustment was applied for the proportion of population that are likely to be ineligible based on citizenship status. Given that pre-tabulated data does not allow for several important adjustments that were applied in the overall population profile developed for the larger project (such as the HIU/GPG adjustment and detailed non-citizen eligibility categories), these county data were subsequently adjusted proportionally to match statewide estimates of currently eligible uninsured below 400 percent of FPL.

Estimated county rate of uninsured eligibles were then compared to statewide and regional average rates of uninsured eligibles. For counties outside of New York City (ROS), if the rate of eligible uninsured is above the average for all counties outside of New York City then the potential enrollment in that county is identified as the number of individuals who would need to be enrolled to place each county at the ROS average. For counties in New York City (boroughs), the opportunity to enroll eligible uninsured was estimated as the number of new enrollees that would be needed to place the borough at the statewide average. The estimated total statewide new enrollment opportunity (65,000) is the sum of the enrollment opportunity for each county that is above the applicable average (ROS or statewide) at baseline.

These estimates assume that NYS would distribute additional Navigator program resources to counties with higher than average uninsurance rates. If resources were distributed differently, or more resources were available including counties that have average or below average uninsurance rates, then potentially a larger (or smaller) number of the remaining eligible uninsured could be enrolled. It is also important to recognize that outreach and enrollment support will never be able to enroll all eligible unenrolled individuals, as some individuals may be unreachable or unwilling to enroll, despite the expanded efforts by the State and Navigator programs. As the share of uninsured declines, on average each remaining individual will be more difficult to engage. However, to date the Navigator program has had a relatively modest cost per individual enrolled, with costs for even the most challenging enrollees in the range of only \$100-\$300 per individual, indicating that there is an opportunity to continue to enroll eligible uninsured individuals at nominal cost to the State through further investment in this program.¹²⁴

No additional costs are estimated associated with the coverage of new enrollees, as this program does not provide any new coverage or benefit eligibility.

Enhanced Outreach and Enrollment – Enable Enrollment through Tax Returns

Estimates for this program are based on the first year of program experience reported by the Maryland Easy Enrollment program, which provides a model that could be adopted in New York State, combined with data from

the 2019 American Community Survey for Maryland and for New York.¹²⁵ First, the share of uninsured eligibles enrolled in Medicaid and QHPs through this program were estimated based on Maryland program data and Census uninsured population data for Maryland segmented by income. These shares were then applied to the uninsured eligible population in New York to estimate the number of potential new enrollees in each program that could result from implementation of this program.

It is important to note that enrollment estimates may be somewhat conservative, as these estimates rely on person level tracking implemented in the Maryland program to link inquiries on tax returns to ultimate program enrollments. It is possible that the program may have produced some additional enrollments that cannot be directly tracked through at the individual level, however it is unlikely that any such indirect or unobserved enrollments would dramatically change the scale of enrollment impact produced by this program.

New York State would bear some administrative cost to implement this program, which is not estimated but is likely to be nominal. New enrollment in public programs would also increase fiscal costs to the State and federal governments. No additional costs are estimated associated with the coverage of new enrollees, as this program does not provide any new coverage or benefit eligibility.

Enhanced Outreach and Enrollment – Extend Marketplace Open Enrollment

No estimate is made for the enrollment or cost impacts of extending or enhancing Marketplace open enrollment periods.

APPENDIX B – BASELINE POPULATION COVERAGE MIX DETAIL

As identified above, for purposes of this paper, CBC and CSS utilized a combination of health insurance coverage information from the ACS and State administrative data to generate a profile of the total New York State population by age, income, immigration status, and unique coverage type. This section provides some additional detail on the data sources and methods used to estimate the baseline and 2023 projected health insurance coverage distribution.

As noted above, for purposes of this analysis the 2023 population baseline coverage mix profile is identical to the estimated coverage mix in 2019. This provides a stable baseline with consistent population and coverage data sources, that are not subject to the many disruptions to the coverage landscape associated with the COVID-19 pandemic. It is of course possible that New York State will not return to a profile that is identical to 2019 by 2023, but this does provide a reasonable baseline for the current analysis given that the magnitude, directionality, and timing of resolution of COVID-19 impacts and the post-COVID equilibrium in population, economic and policy circumstances remain largely unknown. If New York State were to pursue any of the policy proposals in this paper, policymakers may wish to conduct additional analysis to further refine the estimates provided.

In producing the analysis for this paper, the uninsured population is of primary importance.

As described above, the uninsured are identified as individuals who have no other coverage reported on the 2019 ACS. Those reporting one or more coverage categories on the ACS (not uninsured) were assigned hierarchically to a unique coverage category as observed on the coverage variables in the ACS, consistent with the method used by the Kaiser Family Foundation.¹²⁶

However, the coverage categories available in the ACS do not fully represent the programs and categories needed to estimate the impacts of the coverage policies proposed in this paper. Moving beyond the ACS data, this report focused on estimating the number of individuals across programs and coverage categories specific to the policy context in New York State that are most relevant to the coverage proposals. Specifically, these policies include:

- Essential Plan – all enrollees are adults (children would be enrolled in CHP). Enrollment by income level was used as reported in the NYSOH Open Enrollment reports for 2019 and 2020.¹²⁷ It is assumed that EP beneficiaries may self-report as either Medicaid or Private Non-Group coverage in the ACS. However, based on an assessment of Medicaid and CHP beneficiaries and managed care enrollment administrative data in combination with ACS self-reported coverage data, it appears that most EP beneficiaries are likely self-reporting their coverage as private non-group insurance rather than Medicaid.¹²⁸

- On-Marketplace QHPs – enrollment by age and income level was used as reported in the NYSOH Open Enrollment reports for 2019 and 2020, with an additional income distribution of the unsubsidized group above 400 percent FPL based on the distribution of individuals observed in the ACS self-reporting Private Non-Group coverage only (not allocated to other coverage categories through hierarchical assignment).¹²⁹
- Off-Marketplace individual market – enrollment in off-Marketplace plans by age group was used as reported in data provided by the NYS Department of Financial Services (DFS).¹³⁰ In the absence of other information, the income distribution of off-Marketplace individual market enrollees was assumed to be the same as those for on-Marketplace QHPs, with one additional adjustment. While there is no known data to specifically estimate the size of this population, a small number (10%) of the total off-Marketplace enrollees were assumed to be below 200 percent of FPL, as there are likely to be some high-need individuals with assets but no income who may choose to purchase or maintain coverage off-Marketplace to ensure continued access to needed care, including access to specific providers or higher benefit design plans.

Once these coverage categories are taken into account in reference to the populations observed in the ACS segmented by age and income, there were only a small number of

remaining individuals with self-reported private non-group coverage from the ACS who were not otherwise assigned. These are assumed to be either individuals with private coverage purchased out of state, individuals with other than full benefit plans, or possibly misreported ESI coverage.

Finally, while this method yields reasonable coverage mix estimates in aggregate and for the key programs, income and population groups relevant to this analysis, it is important to note that these estimates do not net perfectly across age and income segments. Known challenges such as under-reporting of public coverage and over-reporting of private coverage, as well as navigating the differences between stock and flow populations across data sources, introduce significant limitations to creating a fully consistent profile of small group population cells across all coverage, income, age, and immigration status categories. As such, the estimates presented in this paper should be considered as directionally correct for purposes of evaluating the policy proposals presented, not a source of truth for the coverage and population mix distribution of the New York State population.

APPENDIX C – Immigrant Population Methodological Detail

As discussed in Appendix A, the ACS provides a citizenship variable which enables direct identification of non-citizens in the PUMS data. Since many adult non-citizens are ineligible for public health insurance programs, the ability to distinguish non-citizens from citizens is a critical component of any analysis eligibility and enrollment in public health insurance programs.

Federal eligibility for health insurance coverage programs does not align directly with citizenship status. For example, nationwide, some groups of non-citizens are only eligible for Medicaid coverage after a five-year waiting period (the five-year bar) subsequent to acquiring Lawful Permanent Residence (LPR or “Green Card”) status. That said, a broader group of lawfully present immigrants, including the people in the five-year bar, are eligible to purchase coverage on health insurance Marketplaces with income-based subsidies. A small group of lawful immigrants (e.g. people with DACA status) are ineligible for both federal Medicaid and subsidies.

By contrast the rules in New York State are more generous. For example, many immigrants who are not eligible for health insurance coverage benefits under federal law are eligible for Medicaid, CHP and EP. All non-citizen children are eligible for CHP in New York State, regardless of their immigration status. Among adults, LPR immigrants who are subject to the five-year bar, and immigrants in over a dozen quasi-legal immigration statuses (known collectively as individuals who are Permanently

Residing Under Color of Law or “PRUCOL”) are also eligible for Medicaid and EP with the same income-based eligibility criteria as citizens and federally eligible immigrants (these previously State-only funded immigrants are covered in EP regardless of income).

While all PRUCOL immigrants are eligible for Medicaid in New York State, five groups of “residual” PRUCOL immigrants with incomes above 138 percent of FPL are ineligible for EP. These residual PRUCOLs include people DACA with status and several other smaller PRUCOL immigrant groups who are currently excluded from EP eligibility. Additionally, a large population of undocumented adult immigrants (those who do not fall into any of the defined authorized or PRUCOL immigration status categories) remain ineligible for any of New York’s public health insurance coverage programs. The only public health insurance that these individuals are currently eligible for is Emergency Medicaid, which pays the cost of certain types of care that these individuals receive but is not equivalent to health insurance coverage and Medicaid for pregnant individuals.¹³¹

Historically, researchers seeking to understand the undocumented population in the United States have generally focused on a population called “unauthorized” immigrants. This category includes all foreign-born non-citizens who do not fall into specific categories of “legal” immigration. Legal immigrants include naturalized citizens, LPRs, asylees or refugees, and “legal temporary migrants.” Unauthorized immigrants are all other non-citizens, including those who entered illegally, visa overstayers, and other quasi-legal statuses, such as those with Temporary Protected Status (TPS).¹³²

In relation to the taxonomy outlined above, the operational definition of “unauthorized” immigrants used by researchers clearly includes both PRUCOL immigrants who are eligible for public coverage programs in New York State, and residual PRUCOL and undocumented immigrants who are not eligible for such programs. As a result, for purposes of this study, it was necessary to construct more detailed estimates of coverage categories within the “unauthorized” group.

To accomplish this, first the data published by multiple researchers about the unauthorized population was used to estimate the aggregate of PRUCOL and undocumented immigrants. Then additional administrative data and estimation methods were used to disaggregate the PRUCOL and undocumented groups as subsets of the unauthorized. For purposes of this study, it is necessary to disaggregate citizenship status of the population in four distinct categories:

- Citizens (directly observed in ACS)
- Non-citizens (directly observed in ACS) are distributed into four distinct groups:
 - Authorized non-citizens – proxy for federally eligible immigration statuses.
 - PRUCOL non-citizens – subset of unauthorized that are not federally eligible, but are eligible for public health insurance programs in New York State.
 - Residual PRUCOLs – subset of PRUCOL non-citizens who are estimated as DACA or one of the other four identified residual immigration statuses.¹³³

- Undocumented non-citizens – remaining subset of unauthorized who are not PRUCOL. All undocumented non-citizens are ineligible for comprehensive public health insurance programs in New York State.

Estimates of the “Unauthorized” Immigrant Population

As noted above, most research seeking to disaggregate groups of non-citizens by immigration status has focused on the construct of “unauthorized” immigration. As such, the first step in disaggregating the non-citizen population into the three categories detailed above is to distinguish unauthorized from authorized non-citizens.

According to the most recent estimates by Jeffrey Passel from the Pew Hispanic Center, one of the leading researchers on this topic, New York State has one of the largest unauthorized immigrant populations of any state, surpassed only by California, Texas, and Florida. Passel’s most recent estimate of the unauthorized population in New York State is 650,000 in 2017, a number which has been steadily decreasing from a high of 1 million in 2007.¹³⁴

The Migration Policy Institute (MPI) also estimates the unauthorized population by state, and provides a detailed demographic profile of the unauthorized population. Their most recent published estimate is that there are 835,000 unauthorized immigrants in New York State, based on a 2015-2019 five-year blend.¹³⁵

Since these two estimates are quite different and there is no clear basis to select one source over the other, this study estimates the unauthorized population in 2017 as the average of the Passel 2017 estimate and the MPI 2015-2019 estimate. These results are then trended forward to 2019 to reflect the downward trend in the size of the non-citizen population on the ACS. The observed ACS two year trend from 2017 to 2019 is a 10.5 percent reduction in the total New York State non-citizen population, from 1.97 million to 1.76 million. However, given how large this observed trend is, in the interest of making more conservative estimates the authors applied only half of the observed trend. This results in an estimated total of 700,000 unauthorized immigrants in New York State in 2019. The remaining 1.2 million non-citizens observed in the 2019 ACS are assumed to be authorized non-citizens.

Segmenting the Unauthorized Population into Subgroups of Undocumented and PRUCOL Immigrants

As described above, for purposes of this analysis and modeling coverage options for immigrants who do not currently have access to public health insurance programs in New York State, it is necessary to further segment the “unauthorized” immigrant population into two groups – PRUCOL immigrants and “undocumented” immigrants.

The first step in producing this distribution is reviewing what is known about PRUCOL enrollment in public coverage programs in New York State. For adults, enrollment in the EP categories specific to federally qualified immigrants under the five year bar and

PRUCOL immigrants below 138 percent of FPL (EP3 and EP4) indicates that in 2019, there were roughly 310,000 total immigrants enrolled in these categories.¹³⁶ Of this, based on prior communication from the NYSDOH, an estimated 25 percent are PRUCOL, with the remaining being five-year bar. This results in an estimated 75,000 PRUCOL immigrants with incomes less than 138 percent of FPL enrolled in EP in 2019. Assuming the same take-up rate for EP3/4 among PRUCOL immigrants that is observed in the 2019 ACS for the non-citizen adult population enrolling in Medicaid (28 percent), there are an estimated 270,000 total PRUCOL adult immigrants in New York State in 2019. For PRUCOL children, the take-up rate in Medicaid and CHP is assumed to be equivalent to citizen children at each income level as observed in the ACS. The total estimated PRUCOL population across all age groups is 300,000.

The remaining count of the 700,000 unauthorized non-citizens who are not assigned as PRUCOL are assigned as undocumented non-citizens. This yields a total of 400,000 total undocumented non-citizens in 2019.

Age, Income and Coverage Profile of Detailed Non-Citizen Population Groups

The New York State Unauthorized Immigrant profile published by the MPI provides the primary basis for the age, income and coverage distribution of the total unauthorized population.¹³⁷

The age distribution of the unauthorized population (children, non-elderly adults, elderly adults) is taken directly from the MPI profile age distribution. This age mix is generally

consistent with other sources (including the Pew Hispanic Center) which indicate that a disproportionate share of unauthorized immigrants are working age adults. In the absence of data to inform a distinction (if any) between the PRUCOL and unauthorized non-citizen groups, the same age distribution is used for both.

income levels, MPI provides a useful starting point, but some adjustments are required. It is likely that the MPI reported distribution skews higher income than is realistic for the 2019 unauthorized population profile to be used for this study. First, the MPI income levels are based on the ACS family definition, not the preferred SHADAC HIU/FPG methodology (which produces a lower income distribution than the Census reported FPLs). In addition, it appears that the estimation methods used by MPI do not fully reflect known income disparities among non-citizen sub-groups. The income distribution provided by MPI (based on Census definitions) for the unauthorized population is similar to the ACS income distribution (using HIU/FPG) for all non-citizens. However, earlier studies have clearly identified substantial disparities faced by undocumented individuals relative to the non-citizen population overall, including substantially lower income and higher poverty rates.¹³⁸ Finally, given the large number of low-income immigrants utilizing Emergency Medicaid (an estimated 74,000 unique Emergency Medicaid users in 2019), utilization among the estimated undocumented adults below 138 percent of FPL compared to the raw MPI distribution would yield an unrealistically high rate.

As such, for the estimates presented in this paper, the MPI income distribution was re-scaled to systematically weight the unauthorized population toward lower income levels, bounded by the assumption that the residual authorized non-citizen population income distribution should not be more favorable (higher income) than the total population income distribution. Within the unauthorized population, the income distribution was additionally skewed to assign the undocumented subset to lower income groups relative to the PRUCOL subset, bounded by the assumption that PRUCOL immigrants should not be more favorable (higher income) than the total non-citizen population income distribution. This set of assumptions lead to marginally unauthorized uninsured immigrants and more undocumented immigrants being estimated in the lower income groups, i.e. the groups that are income eligible for the proposed coverage options. This set of design decisions produces a conservative estimate of the immigrant coverage program, in that the program will have higher enrollment and higher cost to the State with regard to income-based subsidy calculations, relative to the estimates that would derive from the given MPI income distribution without adjustments.

With regard to coverage, MPI data is also used to inform the uninsurance rate among the unauthorized population. The overall unauthorized population uninsurance rate is assumed to be the same as is observed by MPI (43 percent). Other sources have suggested higher uninsurance rates among the unauthorized population nationally (as much as 60 percent), however given the additional coverage options available to some unauthorized

immigrants in New York State it is likely that the rate in New York State would be lower than these national averages. In addition, the 43 percent uninsurance rate was validated based on an assumption that this rate must be bounded by total non-citizen and residual authorized immigrant uninsurance rates. A 43 percent overall uninsurance rate among unauthorized immigrants yields an uninsurance rate among the residual authorized immigrants that is roughly equivalent to the total population (including citizens and non-citizens), which provides a reasonable bound for the unauthorized population uninsurance rate.

Given PRUCOL immigrants' access to Medicaid and EP which is not available to undocumented immigrants, and the fact that PRUCOL immigrants can generally be assumed to have better access to ESI and other private coverage options, it is reasonable to assume that uninsurance would be higher among undocumented non-citizens than among PRUCOL non-citizens. However, it can also be assumed that PRUCOL non-citizens are unlikely to be better off with regard to access to health insurance coverage than the total non-citizen population including both the authorized and unauthorized non-citizen groups. Using this bound, a 24 percent net uninsurance rate is assumed among PRUCOL adults (equivalent to the uninsurance rate among the total non-citizen non-elderly adult population), which results in a 65 percent uninsurance rate among the residual undocumented non-citizen adults. The remaining population that is not assigned as either Medicaid/CHP or uninsured is assumed to have private coverage (either ESI or directly purchased non-group coverage).

Finally, to estimate the number of uninsured in the income groups applicable to estimating the impact of the coverage proposals in this paper, uninsurance rates for the total unauthorized, PRUCOL and undocumented populations are assumed to vary by income level. The same principle detailed above is applied per income level, i.e. PRUCOL non-citizen adults are generally assumed to have similar uninsurance rates to the total non-citizen uninsurance rates by income level, and the undocumented uninurance levels by income are the residual of this calculation and yield higher uninsurance

rates at each income level. After that preliminary distribution was implemented, additional adjustments were applied to create a logical distribution across the two unauthorized population groups below 200 percent FPL, accounting for the fact that PRUCOL immigrants have access to Medicaid and EP coverage that is unavailable to undocumented individuals.

Table A2: New York Immigrant Population and Health Insurance Coverage (2023 Estimated Baseline)

	Total Population (All Ages)	Uninsured Population	Uninsurance
Rate	Nominal		
Total Noncitizen Residents	1,760,000	372,000	21%
Total “Unauthorized” Immigrant Residents	700,000	305,000	43%
- Total Undocumented Residents	400,000	238,000	60%
- Total PRUCOL Residents	300,000	67,000	22%
- “Residual” PRUCOL Adults with immigration status that would preclude eligibility for public health insurance programs	26,000	11,000	43%
Total Immigrants Ineligible Due to Immigration Status (Undocumented and Residual PRUCOL) – Any income	426,000	250,000	59%
Immigrants Ineligible Due to Immigration Status and EP Income Eligible (<200% FPL)	245,000	154,000	63%
Total Immigrants Ineligible Due to Immigration Status (Undocumented and Residual PRUCOL) – Any income	426,000	250,000	59%
Immigrants Ineligible Due to Immigration Status and EP Income Eligible (<200% FPL)	245,000	154,000	63%

Notes

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4. Teresa A. Coughlin and others, “Sources of Payment for Uncompensated Care for the Uninsured,” (Kaiser Family Foundation, April 6, 2021), www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/.
5. Teresa A. Coughlin and others, “Sources of Payment for Uncompensated Care for the Uninsured,” (Kaiser Family Foundation, April 6, 2021), www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/.
6. U.S. Census Bureau, “Selected Characteristics of Health Insurance Coverage.”
7. In 2020 and 2021, the COVID-19 pandemic and associated economic impacts caused significant shifts in health insurance coverage. There are many potential dynamics that should be modeled by New York State if any coverage policy proposal were to progress. However, for purposes of this paper, many of these pandemic-related policy changes and market distortions are expected to resolve and return to status quo by 2023. As a result, for purposes of this paper, population coverage estimates are based on 2019 data unless otherwise stated.
8. U.S. Census Bureau, “Selected Characteristics of Health Insurance Coverage,” *supra* n. 1.
9. See the Appendix for data and methods used to estimate the size of these groups.
10. To develop these estimates this report establishes a baseline population profile assuming no intervening state or federal policy changes. The baseline population profile is based on pre-pandemic data sources and assumes that the State’s population and health insurance coverage landscape will return to pre-pandemic equilibrium in 2023. This report estimates direct cost implications of the proposed strategies only. Cost estimates reflect the cost to New York State to provide new benefits or cover newly eligible individuals estimated to enroll; benefit costs of enrolling individuals already eligible are not included. Administrative costs to New York State to implement proposals are also not reflected but are assumed to be relatively small compared to direct benefit and coverage costs. The potential magnitude and directionality of indirect impacts and administrative costs associated with these proposals are discussed in each section where applicable, but further analysis would be required to quantify these dynamics.
11. The FPL is a measure of household income that varies with household composition and size, was originally set to represent a level below which households could not afford basic necessities, and is updated for inflation annually. Examples of the 2019 FPL are \$16,753 for an individual and \$34,638 for a family of four. See U.S. Department of Health and Human Services, “U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs” (accessed December 4, 2021), <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines>. New York had offered public coverage programs for people with incomes above the federal Medicaid levels through a federal 1115 Medicaid Waiver that established the Family Health Plus program that extended public coverage to parents up to 150 percent FPL and childless adults up to 100 percent FPL. Additionally, New York’s CHP program is available to all children, regardless of income or immigration status.
12. An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, P.L. 115-97, 131 State 2054.
13. U.S. Department of Health & Human Services, “Actuarial Value,” (accessed November 19, 2019),

- www.healthcare.gov/glossary/actuarial-value/; and “The ‘metal’ categories: Bronze, Silver, Gold & Platinum” (accessed November 19, 2019), www.healthcare.gov/choose-a-plan/plans-categories/. Catastrophic plans are also available for a select group of enrollees based on age, income, and other characteristics. See U.S. Department of Health & Human Services, “Catastrophic health plans” (accessed November 19, 2019), www.healthcare.gov/choose-a-plan/catastrophic-health-plans/.
14. N.Y.S Ins. Law § 3217-i.
 15. QHPs are certified plans which meet criteria of coverage set by the ACA. See Centers for Medicare and Medicaid Services, “Qualified Health Plan Certification” (April 4, 2019), www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp. New York State created the New York State of Health Marketplace in 2013 as state-administered Marketplace. New York is one of 13 states that chose to create its own Marketplace, and residents of all other states utilize a federal platform to purchase coverage. See U.S. Department of Health & Human Services, “The Marketplace in Your State” (accessed November 18, 2019), www.healthcare.gov/marketplace-in-your-state/.
 16. New York State Department of Health, New York State of Health, *QHP and EP Enrollees by County and Issuer - Individual Marketplace* (September 2021), <https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20Enrollment%20by%20Issuer%20and%20County%20as%20of%201-31-21.pdf>.
 17. See the Appendix for a complete description of the coverage summary and estimated baseline population profile. Individuals may have more than one type of coverage, but the profile set forth in Table 2 assigns a unique coverage category. Economic assumptions are informed by the New York State Division of the Budget’s most recent economic projections, which project a return to pre-pandemic employment by the second half of 2022. See New York State Division of the Budget, *FY 2022 First Quarterly Update* (September 2021), p. 74, www.budget.ny.gov/pubs/archive/fy22/en/fy22en-fp-q1.pdf
 18. New York State of Health, *Health Insurance Coverage Update* (September 2021), https://info.nystateofhealth.ny.gov/sites/default/files/Health%20Insurance%20Coverage%20Update%20-%20September%202021_0.pdf.
 19. New York State Department of Health, *Basic Health Plan Blueprint*, 2017 (November 28, 2017) <https://info.nystateofhealth.ny.gov/sites/default/files/Basic%20Health%20Program%20Blueprint%20Amendment.11.28.2017.pdf>. EP had a \$20 premium for people with incomes between 150 and 200 percent of FPL. This premium was eliminated in the New York State Budget for Fiscal Year 2022. See New York State Department of Health, *Fast Facts on the Essential Plan* (May 2021), https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20Fact%20Sheet_5.pdf.
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 21. Provider reimbursement rates for Essential Plans 3 and 4 are equal to Medicaid rates. Rates for Essential Plans 1 and 2 are equal to Medicaid plus 20 percent. See New York State Department of Health, *Essential Plan (EP) Guidance 1.0* (September 10, 2015), www.health.ny.gov/health_care/managed_care/essential/guidance.htm; and Jodi L. Liu and others, *An Assessment of the New York Health Act* (RAND Corporation Report, 2018), www.rand.org/pubs/research_reports/RR2424.html.
 22. See Community Service Society of New York, *Bridging the Gap: Exploring the Basic Health Insurance Option for New York* (June 2011), www.cssny.org/publications/entry/bridging-the-gapJune2011RevisedJanuary2012; Rockefeller Institute, *New York Individual State Report* (June 2016), https://rockinst.org/wp-content/uploads/2018/02/2016-06-New_York_Individual_Report.pdf; and New York State Department of Health, *Essential Plan New York’s Basic Health Program, 2017*, (December 2017), www.health.ny.gov/health_care/managed_care/essential/docs/2017_annual_report.pdf.
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27. Unpublished data provided to authors by the New York State Department of Financial Services.
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The Citizens Budget Commission (CBC) is a nonpartisan, nonprofit civic organization whose mission is to achieve constructive change in the finances and services of New York City and New York State government. cbcny.org

