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New York State Health Benefit Exchange

Study 5: Healthy New York and the Family Health Plus Employer Buy-In

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1. Introduction

The New York State Department of Health engaged Deloitte Consulting LLP ("Deloitte Consulting") to analyze the impact on the state-sponsored Healthy New York (HNY) and state-administered Family Health Plus-Employer Buy-In (FHP-EBI) programs in a Health Benefit Exchange environment. This report presents our analysis of the potential impact a state-based Exchange may have on the HNY and FHP-EBI enrollees and the state.

HNY and FHP-EBI are programs designed to provide health insurance coverage to segments of the population at risk for going uninsured. HNY is designed to make reduced-cost, comprehensive health insurance available to small employers that do not provide other health insurance to their employees. Eligible individuals whose employers do not provide health insurance and sole proprietors with incomes below 250 percent of the Federal Poverty Level ("FPL") may also purchase coverage through HNY. FHP-EBI is available to all New York State employers regardless of employer size, type, or the income level of employees.

As part of the 2010 Patient Protection and Affordable Care Act ("ACA")[1], states have an option to establish and operate a state run Health Benefit Exchange ("Exchange"). The Exchange can serve as a one-stop resource for consumers to compare and contrast health care options on a variety of dimensions including level of coverage and affordability.

New York State is among those states that have decided to establish and operate an Exchange and is in the process of analyzing implementation options. As part of this analysis, New York State recognized the importance of understanding the impact to individuals and employers currently enrolled in state-supported and state-administered programs and how they will fit into the Exchange environment.

2. Background

A. Healthy New York and Family Health Plus Employer Buy-in

New York created HNY and FHP-EBI to provide health insurance coverage to segments of the New York population at risk of being uninsured. HNY makes reduced-cost, comprehensive health insurance available to small employers that do not provide health insurance to their employees. Eligible individuals who do not have employer sponsored health insurance and sole proprietors with incomes at or below 250 percent of the Federal Poverty Level ("FPL") may also purchase coverage through HNY. FHP-EBI is available to eligible New York State employers to purchase the Family Health Plus benefit package for their employees regardless of employer size, type, or the income level of employees.[2] Key elements of HNY and FHP-EBI include:

Healthy New York (HNY)

- **Legislative History:** The program was introduced as part of New York State's Health Care Reform Act of 2000 as an attempt to tackle rising health care costs by providing a reduced premium program to those New York State residents who struggle to afford health care insurance.

- **Market:** The program was developed to encourage small businesses to provide coverage to uninsured workers and their families. Individuals and sole proprietors who meet the eligibility criteria may also enroll in the program.

- **Eligibility:** To be eligible for enrollment in the program, individuals and sole proprietors must be residents of the State, previously employed (or spouse is employed), and uninsured in the last 12 months. HNY also restricts income levels to no more than 250 percent of the Federal Poverty Level ("FPL") or, for 2012, an annual income of $27,925 for individuals and $57,625 for a family of four. Small businesses may also enroll in HNY if they are located in New York State, have 50 or fewer employees, and have not provided other health insurance in the last 12 months. Additionally, 30 percent of the small business' employees must earn an annual salary less than $40,000. Small employers must contribute at least 50 percent of the premium.

- **Benefits:** At inception HNY offered a standardized medical benefit with pharmacy and, in 2003, added the option to remove the pharmacy benefit. In 2007, HNY added high deductible health plan options. As of January 2012, in an attempt to maintain the program's sustainability, new enrollees can only enroll in a high deductible health plan (with or without pharmacy benefits). This requirement does not affect those who were already enrolled in the original medical plan. Currently there are 13 participating health plan carriers offering high-deductible health plan options to enrollees.

- **Funding:** The State provides reinsurance (stop-loss insurance) to participating health plans according to the amount of medical costs for the enrollee. The State reimburses approximately 90 percent of medical claims paid on behalf of members between $5,000 and $75,000 in a calendar year. Amounts due to the health plans have exceeded the available funding in recent years. As a result, reinsurance payments from the State are prorated based on the available funding. In 2009, the State paid an average per member per month (PMPM) amount of $78 through its reinsurance program for HNY, but this amount varied by health plan within a range of $31 PMPM to $132 PMPM. In 2009, 8.9 percent of members reached the stop-loss threshold (7.8 percent small business, 9.9 percent for sole proprietors and 9.3 percent for individuals). According to a study conducted by the Urban Institute[3], HNY stop-loss subsidies accounted for a 31 percent reduction in premium for individuals and employers in 2011.

- **Enrollment:** Since the enrollment restriction to HDHP plan design was implemented, HNY has seen a reduction in monthly membership. In December of 2011, HNY had enrollment of 178,575 members while in September of 2012, HNY had enrollment of 174,110; a 2.5 percent decrease. As of September 2012, HNY was comprised of 45 percent small businesses, 41 percent individuals and 14 percent sole proprietors.

- **Premium:** HNY premium rates vary by geographic region within New York State. As of 2012, the high deductible health plan with a pharmacy benefit in the New York City region averages a monthly premium of $332 for an individual and $1,010 for a family, while the high deductible health plan without a pharmacy benefit averages a monthly premium of $278 for an individual and $846 for a family.

- **Initiatives:** There are two initiatives receiving funding from the HNY program to provide additional assistance and to offset premium to enrollees in specific counties of New York State. These two pilot programs are called Healthcore and Brooklyn HealthWorks. Due to their similarity with HNY, these programs were not analyzed separately.

    - ***Healthcore***: Healthcore is operated by the Benefit Specialists of New York and began in May 2009. There are 5 different health insurance plans offered by United Healthcare[4]. Healthcore is offered in nine New York counties: Cayuga, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga and Oswego. For individuals and sole proprietors, eligibility requirements are the same as HNY. Small businesses can enroll under the same requirements as HNY, however, there is no minimum contribution requirement. In addition to receiving the premium reduction benefits of the State covering the reinsurance costs, all eligible enrollees receive a 15 percent premium discount with an additional 5 percent reduction for completing a health assessment within 30 days of enrollment. As of 2012, there are 3,900 subscribers.

    - ***Brooklyn Healthworks***: Brooklyn Healthworks is a modified version of HNY administered by the Brooklyn Chamber of Commerce for small businesses. The

program has been in existence since April 2004 and coverage is provided by Group Health Incorporated ("GHI"). The product is available to small businesses (2-50 employees) located in Kings County. The eligibility requirements are the same as HNY, however, there is no minimum contribution requirement. The program was previously offered at a 19 percent discount in addition to the discount provided by the State covering the reinsurance costs, however, due to the popularity of the program and lack of sufficient funds, the additional discount is currently unavailable to new enrollees. As of 2012, there are 805 small businesses with approximately 2,415 employees enrolled.

Family Health Plus Employer Buy-In (FHP-EBI)

- **Legislative History:** FHP-EBI was introduced in 2007 to allow employers to purchase the already successful comprehensive Medicaid expansion program Family Health Plus ("FHP").

- **Market:** The FHP-EBI allows employers and other designated sponsors defined in NYS Social Services Law Section 369-ff as a Taft-Hartley fund or a voluntary employee benefit association established in accordance with the requirements of section 501(c)(9) of the federal Internal Revenue code to buy-in to the FHP-EBI plan design on behalf of their employees and/or members. Since inception there has been little insurance carrier participation in FHP-EBI, with only Emblem Health currently participating.

- **Eligibility:** To be eligible for the program, any size employer or designated sponsor must not have offered health insurance for the last six months (with the exception of qualifying small businesses of less than 51 employees who spend more than 15 percent of their payroll on health insurance benefits). Employers and designated sponsors must also pay at least 70 percent of enrollee premium.

- **Benefits:** The FHP plan design is a comprehensive benefit package including physician services, inpatient and outpatient hospital services, prescription drugs, smoking cessation services, lab tests, x-rays, emergency room and ambulance services, hospice care and other benefits. Copayments are relatively modest compared to commercial insurance at $150 per inpatient discharge; $50 for emergency room services; $150 for outpatient surgery; $10 for primary care visits, dental, lab, radiology , mental health and substance abuse outpatient visits; $25 for specialist visits, therapies, vision and podiatry services; $5 for generic drugs and $15 for brand name drugs. Groups that were participating in or had entered into a Memorandum of Understanding with the State to participate in the FHP-EBI on or before July 1, 2010 are allowed to retain copayment levels that are lower than those stated above.

- **Funding:** Employers or other designated sponsors are required to contribute 70 percent toward the cost of coverage. Subject to federal approval and state appropriation, an employer or other designated sponsor that did not previously offer health insurance coverage to its employees or members, or an employer or sponsor that did offer coverage but whose ability to continue to offer coverage is in jeopardy, as determined by the

Commissioner of Health, may be eligible for state subsidies towards the cost of its share of the premium only for employees or members who would not otherwise be eligible for the State's Medicaid, Family Health Plus or Child Health Plus programs.

- **Enrollment:** FHP-EBI enrollment has dropped from 55,000 in April of 2008 to its current level of 707 as of November 2012. The United Federation of Teachers ("UFT") is currently the only employer or designated sponsor in FHP-EBI. If the FHP-EBI program remains in place, the Department of Health projects enrollment to increase to 1,200 by 2014. There has been no small employer enrollment in FHP-EBI.

- **Premium:** Premium rates vary by region, employer group size, and whether the plan includes dental benefits. Due to the relatively rich benefits, premiums for this plan are higher than typical group plans ranging from a monthly rate of $391 to $479 for individuals in groups up to 50 employees and $351 to $429 for groups over 50 employees. Currently, the only employees/members covered under the FHP-EBI program are eligible child care workers of UFT. State budgets have included a specific appropriation to contribute to the union's cost of purchasing health insurance coverage under the FHP-EBI for child care providers represented by the union who do not otherwise qualify for coverage under Family Health Plus.

Affordability

HNY and FHP-EBI contain a number of elements to help keep the programs affordable. These range from a single set of eligibility rules and a standardized application form to the State providing a subsidy.

To further increase program affordability, the benefit package offered by HNY covers a reduced scope of services. While the program complies with some ACA provisions (e.g., dependent coverage to age 26, no cost sharing for preventative care, and no lifetime limits, coverage for basic health care services such as physician office visits, in-patient hospitalizations, and medically necessary surgical procedures), it does not provide coverage for services such as mental health, substance abuse, dental care, vision care, chiropractic care, skilled nursing facilities, durable medical equipment, and prosthetics. A listing of additional services needed to meet the requirements of the Essential Health Benefits for HNY and estimates of the cost implications can be found in the Appendix. Including these as covered services is estimated to increase the premium levels of the HNY program by approximately 35 percent compared to the HNY benefit plan without pharmacy coverage and by approximately 14 percent compared to the plan which includes pharmacy coverage. Based on the current 74-26 percent split between those with pharmacy coverage and those without, the average HNY premium increase would be approximately 20 percent.

Services covered by FHP-EBI are much more comprehensive than those for HNY. However, changes to the benefit plan will likely be needed in order for it to comply with ACA and state insurance requirements. These benefit changes would increase premiums slightly in order to

comply with essential health benefit inclusion of chiropractic services and the mental health parity regulation, which would eliminate some benefit limitations.

New York is facing several challenges in continuing to offer these two programs. As with most health insurance coverage offered across the nation, the premium costs for both HNY and FHP-EBI continue to increase at a higher rate[5] than either the Consumer Price Index or wages in general. These increases in premium costs have led to a strain on the State's ability to maintain its subsidy levels. The State subsidizes the cost of the HNY plan by covering the program's reinsurance costs. In recent periods the portion of the reinsurance dollars covered by the state is 50 percent of the requested amount. In a further attempt to rein in costs, new members are restricted to a single high-deductible health plan option.

To maintain affordability levels once the impact of ACA compliance is factored into HNY premiums, the State would need to increase its subsidy level by the average of the premium increase, estimated above to be 20 percent. Based on a current subsidy level of $161 million, the additional subsidy funding required is estimated to be close to $32 million at 2012 enrollment levels.

B. The Affordable Care Act

The 2010 Patient Protection and Affordable Care Act ("ACA")[6] was passed by Congress and signed into law, in part, to ensure that all Americans have access to affordable quality health coverage. This is to be accomplished by transforming the current health insurance market by creating Health Benefit Exchanges (Exchanges) where small employers and individuals can shop and compare health insurance plans on a standardized basis. Lower income individuals will be provided with tax credits and subsidies to reduce their premium and cost sharing to more affordable levels. As with the HNY and FHP-EBI programs, a major goal of the ACA is to make affordable health insurance coverage available to individuals at risk of going uninsured. Similarly, ACA establishes a single set of eligibility rules and a standardized application process.

In their current form, HNY and the FHP-EBI programs offer some of the advantages of the Exchange including benefit and premium comparison, direct member enrollment, and customer service support. These advantages will remain in the Exchange environment. A major change under the ACA would be that, since these two programs currently do not require coverage of all state mandated benefits, beginning in 2014, essential health benefits and state mandated benefits in effect prior to January 1, 2012 would need to be covered.

Small employers buying coverage through the SHOP (Small Employers Health Options Program) would benefit from the availability of tax credits if they meet certain employer contribution and participation rules. Additionally, the employers will be able to offer their employees choices of several health plans and this additional employee choice should not add significant additional administrative burden to the employer.

3. Description of Scenarios

In preparation for 2014 and the introduction of the Exchange, New York State must determine the future of the HNY and FHP-EBI programs. The two scenarios studied are described below.

Scenario 1: Programs Continue Off the Exchange, Modified to Meet ACA Requirements

In this scenario, HNY and FHP-EBI remain as state-supported/state-administered programs, existing outside the Exchange. However, the state would modify the programs to be compliant with ACA requirements including the additional coverage for Essential Health Benefits and benefit adjustments necessary under Mental Health Parity regulations. The Exchange will offer plans covering different benefits and out of pocket costs (i.e., a catastrophic, bronze, silver, gold and platinum level plan).

Scenario 2: Discontinue Both Programs

In this scenario both the HNY and FHP-EBI programs are discontinued and current enrollees are required to choose another health insurance option or become uninsured.

4. Scenario Cost and Coverage Analysis

A. Methodology and Modeling

To aid in our analysis, we developed a modified version of Deloitte Consulting's Health Reform Impact Model ("the Model"). The Model was developed to estimate the effects of changes on population health coverage and costs. The Model uses baseline demographic and cost data to estimate the enrollment and cost impacts of reform over future time periods using a range of assumptions developed within the context of ACA. It was used to produce state-level estimates of the impact on member cost and coverage choices under the scenarios described above considering:

1. **The current populations enrolled in HNY–** State-provided and publicly available reports containing enrollment, premiums, and the history of the program were used to understand the current state of these programs. More detail regarding this information is provided in the Appendix, Section A.

2. **Subsidies and premiums associated with various coverage options available in 2014 –** current ACA guidance regarding subsidies available through the Exchange were considered based on income compared to the Federal Poverty Level.

3. **Estimated member coverage preference based on various assumptions –** we used the Model with different assumptions to estimate the impact on cost and coverage choices under the scenarios described above. Detailed assumptions are found in the Appendix, Section B.

In order to provide a broader picture of the New York marketplace and validate findings, we considered various external resources.[1]

B. Simplifying Assumptions and Other Considerations

To simplify the analysis and control the number of scenarios, we made a number of simplifying assumptions. Assumptions pertaining to subsidies, penalties, premiums, risk scores, and out-of-pocket costs are incorporated into our analysis. Some other key simplifying assumptions include:

1. **FHP-EBI** - Due to the low current enrollment in FHP-EBI (707 members in November 2012), the fact that FHP-EBI enrollment is expected increase modestly by 2014, and due to the

[1] Deloitte Consulting publications, published reports, and the HNY and FHP-EBI websites, Kaiser Family Foundation: State Health Facts information, Burns & Associates: Independent Report on Healthy New York Program for Calendar Year 2010, Community Service Society: Three Steps to Affordable Health Coverage for New York's employers, and Urban Institute: The Coverage and Cost Effects of Implementing of the Affordable Care Act in New York State. A complete list of references is found in the Appendix, Section G.

special subsidy provided by the State; we focused our scenario analysis on the HNY program and did not analyze the impact to FHP-EBI extensively. Our analysis of the FHP-EBI program showed that the total net member cost in this program is substantially lower than that of HNY due to the state funding of premium levels, relatively high employer contribution requirements, and the low cost sharing provisions of the FHP-EBI benefit plan.

2. **Relative Cost of Plans Inside the Exchange and Outside the Exchange** – Since the market rules in New York are yet to be defined, we assumed that comparable plans inside the Exchange will cost the same as comparable plans outside the Exchange, with the only difference being available state or Federal subsidies.

3. **Medicaid Expansion** – We assumed that New York will expand Medicaid coverage for all individuals not eligible for Medicare under age 65 with incomes up to 133 percent FPL (effectively 138 percent FPL with the five percent income disregard).

Employer Contributions - It was assumed that employers offering small group coverage under the HNY program contribute 50 percent to the cost of coverage for their employees (this is the minimum requirement in HNY). Under the FHP-EBI program, it was assumed that employers would contribute 70 percent to the cost of coverage for their employees (this is the minimum requirement for FHP-EBI). It was further assumed that if employers drop coverage in 2014 they will provide these funds net of any penalties to their employees in order to help them afford individual health insurance.

1. **Uninsured** – The focus of this analysis is to outline the various coverage options available to current HNY enrollees in 2014 when the Exchange becomes operational and to estimate the relative cost of these options compared with HNY. While there may be some individuals currently in HNY who become uninsured in 2014 for a variety of reasons (including increased cost of insurance), this was not the focus of our analysis and we did not estimate the impact to the number of uninsured.

2. **Total Expected Member Cost** - For the purposes of this analysis, total expected member cost is defined as expected cost for premiums, copayments, and co-insurance less any applicable savings associated with subsidized premiums or cost-sharing and employer contributions. Using this information, we modeled the total expected member costs associated with HNY and other coverage options. Prior to any applicable subsidies, we estimated premiums for HNY, Medicaid, the Exchange (catastrophic plan and metallic tiers), and off Exchange coverage. To determine total expected member cost, we estimated the cost sharing, penalties, and other subsidies available to enrollees by FPL (details on the subsidies and penalties are provided in the Appendix, Section C).

While the analysis is focused on a member's choice based on total expected member costs associated with each coverage option, other considerations are likely to impact the coverage options residents of New York may choose. The following discusses some of the additional considerations that may exist in the 2014 Exchange environment and may affect the choices of individuals, sole proprietors, and small businesses.

1. **Other reasons for selecting coverage** - Examples of other reasons for selecting coverage include purchasers making decisions based on a word-of-mouth or public perception of an insurer. Additionally, though eligible for Medicaid, there may be a stigma related to enrollment in public coverage and some eligible individuals may refrain. These reasons (along with additional reasons presented in the Appendix, Section E), were not modeled but may affect enrollment in the various options in 2014.

2. **Stakeholder perspective –** Representatives of three stakeholders were questioned regarding their opinions related to the current HNY and FHP-EBI programs, and asked for their perspectives on these programs in 2014. The three stakeholders represented New York-based health plans, New York-based businesses, and New York-based groups advocating on behalf of low-income New Yorkers. These stakeholders were chosen to represent the individuals and businesses in the programs as well as the carriers offering the programs. All three stakeholders commented that, in their view, the current HNY and FHP-EBI programs are not working as intended because the costs of both programs are high and the enrollment in FHP-EBI is very low.

   Representatives for the low income advocacy group expressed concerns that HNY has less than comprehensive benefits for a price that is too expensive and believe the Exchange may be a better option for low income individuals. Other stakeholders representing the health plans noted that the HNY population currently represents a small portion of the market and the enrollees are likely to choose a silver level plan in the Exchange. Additionally, they agreed that FHP-EBI is only serving a small, specialized portion of the market that will find alternative coverage if the program is eliminated. The stakeholder representing New York businesses notes that while the programs are well known, the ACA displaces HNY and FHP-EBI. Among all stakeholders, there is an agreement that if the Exchange works as it is intended with a variety of products, there will be little need for current HNY and FHP-EBI programs to remain as coverage options.

3. **Small Group Definition –** Currently, New York State defines small group employers as those with fewer than 50 employees. However, in 2016 it is required that the definition of small group be expanded to 100 employees. The change in definition will broaden the risk pool associated with small group and may affect group premiums. New York State should consider this definition change for 2016 as the change may affect the decision of some small employers moving to the Exchange.

4. **Sole Proprietor Subsidies Concern –** The State has expressed some concern that the calculation of income for sole proprietors may be different for HNY eligibility than for the Exchange in 2014. According to HNY Regulation No. 171 Section 362-4.3 income is regarded as net income for self-employed individuals (with other additions for items like annuities, royalties, dividends on bonds, and rental income). For sole proprietors, income may be verified through the submission of tax returns. According to the ACA, Modified Adjusted Gross Income (MAGI) will be used for calculating subsidies. MAGI is defined as the Internal Revenue Code's Adjusted Gross Income (AGI) and reflects deductions including trade and businesses

deductions, losses from sale of property, and alimony payments. This amount is also found on a tax return. Based on the definitions available, we assumed that the total income used to calculate eligibility of sole proprietors for HNY is the same as the total income used to calculate Exchange premium credits and cost-sharing subsidies.

C. Cost and Coverage Analysis

A modified version of Deloitte Consulting's Health Reform Impact Model ("the Model") was used to produce estimates of the impact on member cost and coverage choices under the scenarios described above.

Scenario 1 Findings: Programs Continue Off the Exchange, Modified to Meet ACA Requirements

Based on the assumptions in the Model, the table below summarizes the impact on member cost and coverage choices under Scenario 1:

Table 1 – Estimated Impact on HNY Member Cost by Coverage Option[1]

Post-ACA Total Member Cost Compared to Pre-ACA HNY Total Member Cost Scenario 1 - HNY Continues Off Exchange									
Income as percent of FPL	Individuals & Sole Proprietors				Small Group				
	Medicaid	Exchange	Off Exchange	HNY*	Medicaid	Individual Exchange**	Off Individual Exchange**	Small Group Market***	HNY
0 to 138%	(100%)				(100%)				
138 to 200 %		(80%)-(50%)	40%-60%	15%-20%		(100%)-(75%)	40%-60%	40%-60%	15%-20%
200 to 250 %		(55%)-(35%)	40%-60%	15%-20%		(85%) - (50%)	40%-60%	40%-60%	15%-20%
250 to 400 %						(35%) - (5%)	40%-60%	40%-60%	15%-20%
400+ %						40%-60%	40%-60%	40%-60%	15%-20%

[1] Based on a comparison the HNY plan covering Pharmacy. Members in HNY plans without pharmacy will see an additional 14% increase in premium rates

* Healthy New York products will see an increase under ACA primarily driven by the addition of Essential Health Benefits

** Small Groups that drop coverage under ACA will see members migrate into the Individual On- and Off-Exchange

***2014 Small Group market includes SHOP exchanges and off-SHOP products since premiums will be equivalent for similar products

Legend
Costs Drop
Costs Equivalent
Costs Increase

Though HNY is still an option for coverage in this scenario, individuals and sole proprietors will likely find the Exchange a more affordable option since eligibility requirements for HNY limits individuals to those under 250 percent FPL and the Exchange offers more valuable premium credits and cost sharing subsidies to this population. The total estimated member costs are accordingly reduced when compared to estimated total member costs under HNY.

Most small business members will also be likely to find less expensive options to choose from in the individual Exchange rather than remain in HNY. Depending on their income levels, we estimate that members could see significant reductions from current HNY cost levels because the value of the Federal subsidy is greater than that provided by the State. Higher income members whose employer drops group coverage are estimated to see their cost increase by 40 to 60 percent from current levels due to the loss of the HNY subsidy and additional benefits required by ACA. For members whose employer continues to offer coverage, but seeks a plan other than HNY,

costs would increase in a similarly significantly manner due to ACA requirements and loss of the State subsidy. However, members whose employer elects to remain in the HNY program are estimated to see their costs increase by an average of 15 to 20 percent due to the additional benefits required to comply with ACA.

Employers that are eligible for the FHP-EBI program are likely to find less expensive options available under ACA. This is primarily driven by the FHP-EBI minimum employer premium contribution requirement of 70 percent, which is not a requirement for coverage purchased through the Exchange.

Employees that remain in the FHP-EBI program who would otherwise be eligible for the FHP program (determined on a sliding income scale based on family size) will have their premium contribution paid for by the State. This premium subsidy for eligible employees along with the rich cost sharing provisions will provide eligible employees a rich benefit option with minimal total member costs. Employees that are not eligible for FHP coverage will still pay low premiums under the FHP-EBI program due to the 70 percent minimum employer premium contribution requirement. These employees will also receive the rich cost sharing provisions provided by the FHP-EBI benefit design. Employees under 200 percent FPL will be eligible for enough premium and cost-sharing subsidies provided under ACA that a Silver plan selection on the Exchange could be an option that provides lower total expected member costs.

Those individuals currently in the two programs who are under 138 percent of FPL will be eligible for Medicaid Expansion and are expected choose Medicaid for coverage in 2014.

Based on the Model assumptions for Scenario 1, it is estimated that when Exchanges are implemented:

- Those HNY members eligible for expanded Medicaid coverage will enroll in Medicaid at a reduced total expected member cost as compared to current HNY cost.

- HNY individuals and sole proprietors who enroll in the individual Exchange will do so at a reduced total estimated member cost compared to current expected member costs under HNY due to Federal subsidies that are estimated to be greater than existing state subsidies.

- Individuals and sole proprietors electing to remain in HNY will see a net increase in their estimated cost due to the additional benefits required to comply with ACA.

- Small employers who drop group coverage:

    - Those non-Medicaid eligible employees below 400 percent of FPL who enroll in the individual Exchange should see a reduced total estimated member cost compared to HNY primarily due to Federal subsidies that are estimated to be greater than existing state subsidies.

- Employees above 400 percent of FPL will have total estimated member cost in the individual market that are higher than those in current HNY due to the lack of Federal or state subsidies and the inclusion of additional benefits to meet EHB.

- Employees at all income levels buying coverage off the Exchange will see increases in their net cost compared to their HNY cost due to the loss of the state subsidy, a lack of a federal subsidy off Exchange, and the inclusion of additional benefits to meet EHB.

- Small employers who retain group coverage:

    - Group coverage available on or off the Exchange will be have higher cost compared to current HNY levels due, in part, to the additional benefits required to comply with ACA and the absence of State subsidies.

    - Groups electing to remain in HNY will see costs increase primarily due to the additional benefits required to comply with the ACA.

- Virtually all individuals in HNY earning less than 400 percent of the FPL will have options to buy enhanced coverage through the Exchange with a total estimated member cost that is less than or equal to HNY's estimated member cost.

- To make HNY compliant with ACA requirements, but remain affordable comparable to current costs, per member state subsidization costs must increase. While funding levels have slipped in recent years to where reinsurance claims are paid at approximately 50 cents on the dollar, to maintain current funding levels the subsidy would have to increase at the same rate as premiums increases to account for ACA requirements. We estimate this to average about 20 percent or an additional $32 million in state subsidy.

- For FHP-EBI, it is expected that most UFT members will elect to remain covered under the FHP-EBI program if FHP-EBI continues and if the State continues to subsidize UFT members' enrollment in the program. Although the Exchange does not have income data for UFT members, the national average income for child care workers in 2010 was below 200 percent of the poverty level.[7] While the MAGI household income of UFT members is unknown, this statistic indicates that UFT members may be eligible for premium tax credits and cost-sharing reductions in the Exchange. Nonetheless, UFT members transferring from the FHB-EBI program to commercial Exchange coverage might face an increase in costs because the premium tax credits and cost-sharing reductions may not be as rich as the full FHB-ESI subsidy that members currently receive. Going forward, if New York offers a Basic Health Plan, national income data suggests that UFT members may be eligible for this subsidized program.

Scenario 2 Findings: Discontinue HNY and FHP-EBI Programs

Based on the assumptions in the Model, the table below summarizes the impact on member cost and coverage choices under Scenario 2:

Table 2 – Estimated Impact on HNY Member Cost by Coverage Option[1]

Post-ACA Total Member Cost Compared to Pre-ACA HNY Total Member Cost Scenario 2 - HNY Discontinued							
Income as percent of FPL	Individuals & Sole Proprietors			Small Group			
	Medicaid	Exchange	Off Exchange	Medicaid	Individual Exchange**	Off Individual Exchange**	Small Group Market***
0 to 138%	(100%)			(100%)			
138 to 200 %		(80%)-(50%)	40%-60%		(100%)-(75%)	40%-60%	40%-60%
200 to 250 %		(55%)-(35%)	40%-60%		(85%) - (50%)	40%-60%	40%-60%
250 to 400 %					(35%) - (5%)	40%-60%	40%-60%
400+ %					40%-60%	40%-60%	40%-60%

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* Healthy New York products will see an increase under ACA primarily driven by the addition of Essential Health Benefits

** Small Groups that drop coverage under ACA will see members migrate into the Individual On- and Off-Exchange

***2014 Small Group market includes SHOP exchanges and off-SHOP products since premiums will be equivalent for similar products

Legend
Costs Drop
Costs Equivalent
Costs Increase

Similar to Scenario 1, it is expected that those members eligible for Medicaid Expansion will likely assume this coverage. Of the remaining HNY population, individuals and sole proprietors will likely find the Exchange a more affordable option since eligibility requirements for HNY limits individuals to those under 250 percent FPL and the Exchange offers more valuable premium credits and cost sharing subsidies to this population. The total estimated member costs are accordingly reduced when compared to HNY.

Most small business members will likely find less expensive options to choose from compared with their previous cost in HNY. Depending on their income levels, we expect members electing coverage from the Exchange could see significant reductions from current HNY cost levels because the value of the Federal subsidy is greater than that provided by the state. Higher income members whose employer drops group coverage are estimated to see their cost increase by 40 to 60 percent from current levels due to the loss of the HNY subsidy and additional benefits required by ACA. For members whose employer continues to offer coverage but seeks a plan other than HNY, costs will increase compared to those of the current HNY program because of the additional benefits required by ACA and the loss of the state subsidy.

If the FHP-EBI program is no longer an option, employers should be able to find similarly priced options on the SHOP Exchange. These options will likely have a less rich benefit design than the FHP-EBI option and will result in higher out of pocket costs for the member. Losing the FHP-EBI

option could result in an increase in total member cost of approximately 200 percent for employees whose employers choose a SHOP plan and are not otherwise eligible for FHP or Medicaid services. This is primarily due to the lower expected employer contribution levels and the higher expected cost-sharing payments made by the employee.

The employees who are eligible for the FHP program are expected to join FHP if the employer decides to drop health insurance coverage. If the FHP-EBI employer decides to drop coverage under ACA, employees not eligible for FHP but who have an income below 200 percent FPL should be able to find coverage that is similar to or less than their current total member costs. Those employees not eligible for FHP who make over 200 percent FPL will likely see a significant increase in total member costs if they lose employer sponsored coverage.

Based on the Model assumptions for Scenario 2, it is estimated that when Exchanges are implemented:

- HNY members eligible for expanded Medicaid coverage will enroll in Medicaid at a reduced total estimated member cost compared to current HNY cost.

- HNY individuals and sole proprietors who enroll in the individual Exchange will do so at a reduced total estimated member cost compared to current HNY cost due to Federal subsidies that are estimated to be greater than existing state subsidies.

- Small employers who drop group coverage:

    - Those non-Medicaid eligible individuals below 400 percent of FPL who enroll in the individual Exchange will see a reduced total estimated member cost compared to current HNY primarily due to Federal subsidies that are estimated to be greater than existing state subsidies.

    - Employees above 400 percent of FPL will have total estimated member cost in the individual market that are higher than current HNY cost due to lack of Federal and state subsidies

    - Employees at all income levels buying coverage off the Exchange will see increases in their net costs compared to the HNY cost due to the loss of the state subsidy and lack of a federal subsidy off Exchange.

- Small employers who retain group coverage:

    - Group coverage available on or off the Exchange will have higher costs compared to current HNY levels due, in part, to the additional benefits required to comply with ACA and the absence of State subsidies.

- Virtually all members in HNY earning not more than 400 percent of the FPL will have an option to buy enhanced coverage through the Exchange at a total estimated member cost that is less than or equal to current HNY cost.

- The state will save the current subsidization costs of approximately $161 million dollars annually.

Although the Exchange does not have income data for UFT members, the national average income for child care workers in 2010 was below 200 percent of the poverty level. While the MAGI household income of UFT members is unknown, this statistic indicates that UFT members may be eligible for premium tax credits and cost-sharing reductions in the Exchange. Nonetheless, UFT members transferring from the FHB-EBI program to commercial Exchange coverage might face an increase in costs because the premium tax credits and cost-sharing reductions may not be as rich as the full FHB-EBI subsidy that members currently receive. Going forward, if New York offers a Basic Health Plan, national income data suggests that UFT members may be eligible for this subsidized program.

Basic Health Plan (BHP) Option

If a BHP is included as an option, we estimate that the participation in the metal level plans (platinum, gold, silver, and bronze) for individuals, sole proprietors, and small businesses will all decrease from levels without the BHP. The reason behind this presumed drop is that a BHP offers a robust level of health care benefits at very favorable cost to the eligible enrollee. If a state offers a BHP, then eligible individuals (adults with income between 133 and 200 percent of the federal poverty level (FPL), and legally resident immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from Medicaid) would not be eligible for Exchange subsidies. Instead, the BHP provides states 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs. Under a BHP, a state would contract with health plans and providers to provide at least the minimum essential benefits under ACA, and cannot charge enrollees more than what they would have paid in the Exchange.

If NY chooses to offer a BHP, members in the individual and small group market with incomes under 200 percent FPL would be more likely to choose the BHP due to its low cost, high benefit package. Similar to the assumptions around Medicaid coverage, those eligible for the BHP would most likely enroll in it.

5. Appendix

A. New York State Provided Information

In performing our analysis, we relied on data and other information provided by the State (through the New York State Department of Financial Services) and available publicly. We have not audited or verified this data. If the underlying information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. The following information was provided by the State:

- Enrollment information for the following programs: Medicaid Managed Care, Family Health Plus (Adults with and without children only), Managed Long Term Care, Medicaid Advantage, Medicaid Advantage Plus,
- Healthy New York Information Hotline statistics, Year End 2011
- Social Service Law Article 5 Assistance and Care Title 11-D. Family Health Plus Program
- Family income of nonelderly employees by firm size, 2010
- Section 4326 of New York State Insurance Law
- Healthy New York enrollment from February 1, 2001 to September 1, 2012 by carrier
- March 1, 2011 and September 1, 2012 enrollment by carrier and by enrollee type

B. Modeling Assumptions

Deloitte Consulting's Health Reform Impact Model ("the Model") was used to produce state-level estimates of member costs and coverage patterns in 2014. Our modeling analyzes core aspects of the Model and customized it to New York State's specific healthcare market and incorporated the program characteristics of HNY. Our modeling approach estimates total member costs by analyzing premiums net of subsidies and adding in cost sharing estimates calculated using actuarial values. The premium rates were gathered from publicly available 2012 HNY rates and estimated 2010 New York non-HNY premium rates[8].

The current populations enrolled in HNY was provided by the State and publicly available reports containing current enrollment, premiums, and the history of the program were used to understand the current states of these programs. State provided information is detailed in the Appendix, Section A.

The following assumptions were used to estimate total member costs in 2014:

- We ignored the effects of trend assuming that trend would impact all options roughly equally.
- The employer contribution for current HNY small groups is 50 percent. Health care services required by ACA and state regulations will be added to the benefit package offered by HNY and FHO-EBI driving up premium cost.

Due to the subjective nature of any future estimates, results are highly uncertain, and multiple scenarios are modeled to illustrate some of the potential variation. The results and therefore interpretation of the results rely on the underlying data and the assumptions used in the analysis.

Appendix Exhibit 1: Assumptions

Item	Definition/Description	Sources and Assumptions
Legal/ACA		
Individual Mandate	Size, basis and timing of penalties for those without health care coverage	ACA provisions without adjustments
Exchange availability to individuals	Date at which the Exchange is established and subsidies can be processes	Jan 1, 2014
Exchange availability to groups	Date at which SHOP Established and group sizes allowed over time	Assume SHOP for groups <50 on Jan 1, 2014
Medicaid		
Effective Income Limit	The maximum income level for which the federal government allows eligibility	138% of FPL (133% + 5% disregard)
HNY Coverage		
Plan design assumptions	The loss ratio, actuarial vale and expected employer cost share for HNY coverage	Loss Ratio: 80% Estimated Actuarial Value: 77% based on http://hcfany.files.wordpress.com/2010/07/fhp-brieffinal.pdf Employer cost share: 50%
Average premiums	The average premiums for HNY coverage in 2014	January 1, 2012 rates for NYC and Westchester and the Non-NYC area rates were used for the purposes of this study. Average rates were developed using the population distribution of NYC and Westchester and Non-NYC areas. Rates for Aetna, Atlantis, Empire and GHI-HMO were used. An underlying medical trend of 6.5 percent per year was used to develop expected 2014 premium rates.

Exchange Coverage		
Expected cost sharing with each coverage option	The percentage of medical claim expenses that will be paid by the member. This is based on the exchange tier requirements.	Catastrophic: 50% (assumed average value) Bronze: 40% Silver: 30% Gold: 20% Platinum: 10%
Subsidy eligibility	The percent of individuals on the Exchange that are eligible for subsidies	It is assumed that all of the HNY individuals that will join the individual Exchange market will be eligible for subsidized coverage.

Commercial Coverage		
Expected average cost sharing for off-exchange coverage	Used to estimate the average cost sharing of off Exchange coverage	Off Exchange Cost Sharing: 40%

C. Premium Credits and Cost Sharing Subsidies

Beginning in 2014, individuals who are enrolled in a health benefits plan purchased through an Exchange may be eligible for a premium credit or cost-sharing subsidy. The premium credit is available to people with incomes up to 400 percent FPL, excluding undocumented immigrants and individuals eligible for other health coverage such as Medicare, Medicaid, Family Health Plus, and Child Health Plus. The premium credits will be granted on a sliding scale and tied to the second lowest silver plan available in the Exchange and will set the highest percentage of income spent on health insurance premiums. Premium credits can be used for all metallic tiers of the Exchange but for catastrophic plans. Cost sharing subsidies are offered to the non-group Exchange to reduce the cost sharing amounts by increasing the actuarial value of the plan. Eligible individuals must be enrolled in a silver plan. All HNY individual and sole proprietor members are eligible for premium subsidies and a large majority of HNY small group members are eligible. The table details premium and cost-sharing subsidies available by FPL level.

Appendix Exhibit 2 - Premium Credits and Cost-Sharing Subsidies by Federal Poverty Level

Household Income (percent of FPL)	**Net Premium for second lowest price silver plan** (percent of income)	**Cost-Sharing Subsidy** (maximum enrollee cost share)
100-133 %	2 %	6 %
133-150 %	3 - 4 %	6 %
150-200 %	4 - 6.3 %	13 %
200-250 %	6.4 - 8.05 %	27 %
250-300 %	8.05 – 9.5 %	N/A
300-400 %	9.5 %	N/A

D. Small Business Tax Credit ("SBTC")

The Internal Revenue Service administers the small business tax credit to eligible employers. Currently for tax years 2010 to 2013 the tax benefit is 35 percent for small businesses and is expected to be enhanced for two years from 2014 to 2016. Eligible businesses must have 25 or fewer full time employees with average wages of its employees less than $50,000 and contribute at least 50 percent of the total premium for each employee. The tax credit will be offered based on a sliding scale of employee size and income level of employees. The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than $25,000. This credit will affect how small businesses make decisions about their health care insurance.

E. Essential Health Benefits

As of October 1, 2012 New York State announced its EHB package[9]. It is required that non-grandfathered plans in the individual and small group markets offer the EHB. It is assumed that HNY and FHP-EBI are subject to the EHB requirements and will need to enhance its benefit package to comply with ACA's requirements. The table below summarizes the benefits not currently offered in HNY and FHP-EBI.

Appendix Exhibit 3: Illustrative Essential Health Benefits Package

HNY*	FHP-EBI**
➢ Skilled Nursing Facilities ➢ Hospice ➢ Chiropractic Services ➢ Ambulatory Patient Services ➢ Chronic Disease Management (other than diabetic) ➢ Eating Disorders - Comprehensive Care Centers ➢ Standard Durable Medical Equipment ➢ Prostheses (internal and external) ➢ Rehabilitation Services ➢ Habilitative Services ➢ Home Health Care Services ➢ Mental Health Treatment Services ➢ Chemical Dependence Services ➢ Transportation Services - Ambulatory ➢ Vision Services ➢ Dental Services ➢ Hearing Related Services ➢ Infertility Services ➢ Family Planning/Reproductive Health Services ➢ Foot Care Services ➢ Smoking Cessation ➢ Autism Spectrum Disorders	➢ Skilled Nursing Facility ➢ Habilitation Services^ ➢ Mental Health Services^ ➢ Infertility Services ➢ Autism Spectrum Disorders ➢ Chiropractic Services

http://www.healthbenefitexchange.ny.gov/resource/essential-health-benefits-new-york-health-benefits-exchange

*Compared to CDHP offering of HNY – HDHP Benefit Package http://www.cdphp.com/Members/Health-Plan/Individual-Insurance/~/media/Files/members/healthy-new-york-sole-prop-small-group-summary.ashx

**Compared FHPlus Benefit descriptions in Appendix K - http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

^May have some benefit limitations

Based on our modeling, we estimate the premium cost for the HNY benefit package to increase between 14 and 38 percent in order to comply with all federal and state insurance requirements, depending on whether the current benefit package covers pharmacy (currently, pharmacy is an optional benefit under HNY). The bulk of this increase, roughly 20 percent, is to cover pharmacy services. Appendix Exhibit 4 below sets out some of the biggest contributors to this estimated premium increase. Of the remaining services to be covered, mental health and substance abuse services account for the majority of the residual premium increase.

Appendix Exhibit 4: Estimated Increases to HNY Premiums Due to Additional Essential Health Benefits

Estimated Increase to HNY Premium Due to EHB	
Added Benefit	**% Increase**
Pharmacy	20.9%
Maternity/Newborn	8.8%
Mental Health/Substance Abuse	3.9%
Durable Medical Equipment	0.9%
All Other	0.1%
Total	34.6%

FHP-EBI's benefit package is very comprehensive and covers almost all services required by ACA with the exception of some minor services such are rehabilitative care and some limitations on mental health services. Based on our modeling, the premium increase required for these additional services will be negligible.

F. Alternative Reasons for Selecting Coverage

To predict the enrollment in various coverage options it is important to understand the reasons why individuals and employers choose various coverage options. Though these reasons are not inclusive of all possible reasons, there are several key reasons that are weighed before an individual enrolls in a healthcare plan. We have identified the following key drivers of why individuals and employers choose coverage.

Appendix Exhibit 5

Reason	Applicable Party	Description
Eligibility	Individuals	With the extension of eligibility requirements for Medicaid, those that become eligible will likely choose the discounted health care. In addition, if individuals are eligible for a catastrophic plan they may also weigh the option more heavily.
	Employers	For businesses under 50 employees, the SHOP Exchange is a viable option for coverage. However, in 2016 the definition of a small business will extend to businesses with fewer than 100 employees and the option of Exchange coverage will extend to more businesses.
Penalties not having minimum essential coverage	Individuals	ACA includes penalties for individuals that do not have minimum essential coverage[10]. These penalties will likely encourage individuals to get coverage. Below are the penalties[11] for 2014 through 2016: ➢ **2014**: greater of $95 or 1 percent of household income ➢ **2015**: the greater of $325 or 2 percent of household income ➢ **2016**: the greater of $695 or 2.5 percent of household income
	Employers	Employers are also subject to penalties for not offering minimum essential coverage. For large employers (over 50 employees) penalties range based on if there is at least one Full-Time Employee ("FTE") that receives a premium tax credit. If the employer does not offer coverage and has at least one FTE who receives the credit, a penalty of $2,000 per FTE will be applied. However if coverage is offered, the lesser penalty of $3,000 for each employee receiving premium tax credit or $2,000 for each FTE will be applied. The first 30 employees are excluded from the assessment.
Guaranteed Issue	Individuals	ACA prevents insurers from refusing coverage based on previous health conditions. The range of health care options is now expanded for those that may have previously been denied coverage.
Availability of Information on Coverage	Individuals and Employers	Individuals and employers are likely to make choices on coverage based on what they know. The availability of information about the coverage options will affect the decision. Additionally, the familiarity that individuals and employers have with different plan designs and plan features will play a role in which coverage is selected.
Miscellaneous Reasons	Individuals and Employers	There are various reasons that may fit the category of emotional reasons. For example, if word-of-mouth evaluates plan designs, carriers or benefits positively or negatively purchasers are likely to be persuaded.

G. References

Federal guidance has been provided in the following documents:

- **The Patient Protection and Affordable Care Act ("ACA")**: Sec. 1302. Essential Health Benefits Requirements; http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
- **HHS Bulletin: "**Actuarial Value Bulletin**";** February, 2012; http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

Additional guidance has been provided in the following documents:

- **Burns & Associates, Inc. "**Independent Report on the Health NY Program for Calendar Year 2010"; December, 2010; http://www.dfs.ny.gov/healthyny/reports/hny2010rep.pdf
- **Community Service Society; "**Covering More New Yorker's While Easing the State's Budget Burden"; June, 2011; http://www.healthbenefitexchange.ny.gov/resource/bridging-gap-exploring-basic-health-insurance-option-new-york
- **Community Service Society; "**Three Steps to Affordable Health Coverage For New York's Employers"; June, 2010; http://hcfany.files.wordpress.com/2010/07/fhp-brieffinal.pdf
- **Congressional Budget Office: "**CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance"; March, 2012; http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf
- **Congressional Research Service; "**Treatment of Noncitizens Under the Patient Protection and Affordable Care Act"; March, 2011; http://www.ciab.com/WorkArea/DownloadAsset.aspx?id=2189
- **Family Health Plus Employer Buy-In Website;** http://www.health.ny.gov/health_care/managed_care/family_health_plus_employer_buy-in/
- **Healthy New York Website;** http://www.dfs.ny.gov/healthyny/
- **"**Health Reform for Small Businesses: The Affordable Care Act Increases Choice and Saving Money for Small Businesses"; http://www.whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf
- **Kaiser Family Foundation; "**Determining Income for Adults Applying for Medicaid and Exchange Covered Subsidies; How Income Measured With a Prior Tax Return Compares to Current Income at Enrollment"; March, 2011; http://www.kff.org/healthreform/upload/8168.pdf
- **Kaiser Family Foundation; "**Expanding Health Care Reform: Questions About Insurance Subsidies"; July, 2012; http://www.kff.org/healthreform/upload/7962-02.pdf

- **Kaiser Family Foundation; "**Immigrants' Health Coverage and Health Reform: Key Questions and Answers"; December, 2009; http://www.kff.org/healthreform/upload/7982.pdf
- **Kaiser Family Foundation; "**State Health Facts: New York"; http://www.statehealthfacts.org/profileglance.jsp?rgn=34
- **Kaiser Family Foundation; "**Summary of New Health Reform Law"; April, 2011; http://www.kff.org/healthreform/upload/8061.pdf
- **The Lewin Group; "**Bending the Health Care Cost Curve in New York State; Options for Saving Money and Improving Care"; July, 2010; http://www.lewin.com/~/media/lewin/site_sections/publications/nyshealthbendingthecurve.pdf
- **The Lewin Group; "**The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending," December, 2010; http://www.lewin.com/~/media/lewin/site_sections/publications/lewin_impact_of_medicaid_expansions_on_state_spending.pdf
- **McKinsey & Company; "**Reform Center Health Intelligence: Insights from the McKinsey Center for U.S. Health System Reform"; March, 2011; http://healthreform.mckinsey.com/~/media/Extranets/Health%20System%20Reform/Intels/Health%20Intel%20Basic%20Health%20Plan_032411.ashx
- **National Health Law; "**The Basic Health Plan Option: Considerations for States Implementing Federal Health Reform"; December, 2010; http://www.healthlaw.org/images/stories/Short_Paper_2_The_ACA_and_the_Basic_Health_Option.pdf
- **NYC Human Resources Administration; "**2012 Income and Resource Standards and Federal Poverty Levels (FPL)"; January, 2012; http://www.nyc.gov/html/hra/downloads/pdf/income_level.pdf
- **NYS Health Foundation; "**Implementing Federal Health Care Reform: A Roadmap for New York State"; August, 2010; http://www.healthbenefitexchange.ny.gov/sites/default/files/roadmap_for_nys.pdf
- **Urban Institute; "**The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States"; March, 2011; http://www.urban.org/uploadedpdf/412322-Basic-Health-Program-Option.pdf
- **Urban Institute; "**The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State"; March, 2012; http://www.healthbenefitexchange.ny.gov/sites/default/files/2012-03_urban_institute_report.pdf

[1] Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[2] http://www.health.ny.gov/health_care/managed_care/family_health_plus_employer_buy-in/index.htm

[3] Urban Institute**; "**The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State"; March, 2012; http://www.healthbenefitexchange.ny.gov/sites/default/files/2012-03_urban_institute_report.pdf
[4] http://www.hnyhealthcore.com/index.php

[5] HNY 2010 report (http://www.dfs.ny.gov/healthyny/reports/hny2010rep.pdf) and current premiums from the HNY website http://www.dfs.ny.gov/healthyny/hny_rates.htm. The recent FHP premium rates show an annual increase of 5.8% (http://www.health.ny.gov/health_care/managed_care/family_health_plus_employer_buy-in/docs/premiums.xls) and the HNY website shows an premium increase of 9% from 2009 to 2010.
[6] Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[7] Bureau of Labor Statistics http://www.bls.gov/ooh/personal-care-and-service/childcare-workers.htm
[8] Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits (AHIP July 2011)
[9] http://www.healthbenefitexchange.ny.gov/sites/default/files/ehb_letter_to_hhs_10-1-2012_final.pdf - illustrative benefit package presented in Exhibit 3 of the following link: http://www.healthbenefitexchange.ny.gov/resource/essential-health-benefits-new-york-health-benefits-exchange
[10] "The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage." http://www.healthcare.gov/glossary/M/minimumessentialcoverage.html
[11] Dependents under the age of 18 are subject to half of the above penalty amounts and exemptions will be granted for some circumstances. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples)." http://www.kff.org/healthreform/upload/8061.pdf