NEW YORK STATE HEALTH BENEFIT EXCHANGE
REGIONAL ADVISORY COMMITTEES
SEPTEMBER 2012

In September 2012, The New York State Health Benefit Exchange convened its Regional Advisory Committee by appointing over 200 individuals to serve on one of five Committees across the state. The Committees are comprised of representatives from many important audiences including consumers, small businesses, health care providers, insurance carriers, insurance producers, unions and Tribal nations. Each Committee met for the first time in their home region to hear an update on Exchange planning and progress, and to discuss several implementation and policy issues currently under consideration by the Exchange. The meetings were open to the public and observed by additional stakeholders both in person and via a live web cast. The meetings were facilitated by a panel comprised of staff from the Exchange and the Departments of Health and Financial Services. The Panel included:

- Donna Frescatore, Executive Director, Health Benefit Exchange
- Danielle Holahan, Director of Policy and Planning, Health Benefit Exchange
- Troy Oechsner, Deputy Superintendent for Health, Department of Financial Services
- Judith Arnold, Director, Division of Health Reform and Health Insurance Integration, Department of Health
- Sherry Tomasky, Project Coordinator, Health Benefit Exchange

The following Regional Advisory Committee members were in attendance:

September 13, 2012 - Western NY

Fred Cohen, Anne Constantino, Ann Converso, Patty DeVinney, Pamela Germain, Jared Gross, Dr. William Hall, Donna Kahm, Christopher Kempton, Ellen Kennedy, Dr. Thomas Madejski, Betty Murphy, Brian Murphy, Paul Stasiak, Dr. Ed Stehlik, Todd Thomas, Todd Tranum, Craig Turner, Kim Urbach

September 14, 2012 - Central NY/Finger Lakes

Reuben Auspitz, Christopher Booth, Lenore Boris, Frank Caliva, Mary Clark, Ruben Cowart, Rose DiVirgilio, Terry Engels, Gary Fitzgerald, Daniel Goetzmann, Steven Goldstein, Andrea Haradon, John Holleran, Denise Karsten, David Klein, Dr. Joseph Maldonado, Jean McPheeters, Jeffrey Nagel, Wade Norwood, Kevin O'Keefe, David Oliker, Meg Parsons, Maureen Pelose, Marilyn Pinsky, Dr. Joseph Stankaitis, Christine Wagner, Lea Webb, Steve Wood, Mary Zelazny

September 19, 2012 – Capital District/Mid-Hudson/Northern NY

Mark Baker, David Bauer, Dr. John Bennett, Kate Breslin, Dr. Jason Brown, Dr. Alvaro Carrascal, Georganne Chapin, Bob Cohen, Dan Colacino, Lauri Cole, John Coppola, Joseph D'Allaird, Paul DiFabion, Keith Dolan, Garry Douglas, Sally Dreslin, Caren Fairweather, Gary Fitzgerald, Lev Ginsburg, Jeffrey Gold, Denise Gonick, Dr. Robert Hughes, Lara Kassel, David Lucas, Paul Macielak, Debra Martin, Karin Moran, Peter Newell, Brian O'Grady, Ronald Quartimon, Dr. Mary Rappazzo, Ryan Silva, Donald Smith, Michael Smith, Chuck Steiner, Lori Thompson, Francine Turner, Ellie Ward, Vicky Wheaton-Saraceni

September 24, 2012 – Long Island

Lou Basso, Dr. David BenEliyahu, Roger Clayman, Brian Currie, Kevin Dahill, Howard Gold, Mark Jaffe, Lisa Kessler, Steve Logan, Daniel McCarthy, Gwen O'Shea, Dr. Charles Rothberg, Jay Schoenfeld, James Schutzer, Denise Smith, Lisa Tyson, Bob Wychulis, Kathleen Brennan

September 25, 2012 – Metro NYC

Monica Alexandris-Miller, Amy Allen, Vincent Ashton, Joseph Baker, Linda Baran, Elisabeth Benjamin, Alice Berger, Cara Berkowitz, Maura Bluestone, Michele Bonan, Dr. Jo Ivey Boufford, Wendy Brennan, Andrea Cohen, Kerry DeWitt, Daniel Finke, Beth Finkel, Jack Friedman, Benjamin Geyerhahn, William Golden, Lorraine Gonzalez-Camastra, Lou Gordon, Marsha Gordon, Mark Hannay, Gay Hartigan, Craig Hasday, Paloma Hernandez, Bill Hohlfeld, Dr. Andrew Kleinman, Dr. Linda Landesman, Ilene Margolin, Dr. Chris Morrison, Dr. Mary Beth Morrissey, Jeanette Nigro, Theo Oshiro, Ellen Rautenberg, Carol Rodat, Charles Rollins, Kate Rose, David Sandman, Dr. Arnold Saperstein, Helen Schaub, Kathleen Shure, Heidi Siegfried, Dr. Michael Stocker, Chris Swanker, Dr. Hal Teitelbaum, Suki Terada Ports, Dr. Sam Unterricht, Lois Uttley, Liliana Vaamonde, Jacqueline Vimo, Mark Wagar, Pat Wang, Kim Williams, Robert Wychulis, Heesoo Yeo

Overview and Background:
Members received a briefing on the functions of the New York Health Benefit Exchange, established through Governor Andrew Cuomo's Executive Order number 42 on April 12, 2012, as set forth in the Patient Protection and Affordable Care Act (ACA). The Exchange's organizational chart was reviewed, showing the organizational structure of the Exchange and the important working relationships with the New York State Department of Financial Services as the primary regulator of insurers in New York and the Department of Health as the single state agency for Medicaid.

The vision and expectations of the Regional Advisory Committees were explained. The Committees will serve as the core of stakeholder engagement for the Exchange, but will not preclude additional, broader stakeholder events and communication as needed. The charge of the Committees is to provide advice on key policy decisions to the Exchange through the lens of unique regional perspectives. Committees will meet in person as well as through conference calls and webinars, and can expect ongoing electronic communications and solicitations for comments on various issues. Committee members were reminded that they serve as a direct link to their respective constituencies and were thanked for their commitment to helping reach the goals of the Exchange.

The panel gave a recap of federal Exchange grant awards to New York to date including the most recent Level One Establishment grant of $95.5 million awarded in June 2012 to continue the planning process by supporting the development of the information technology systems; staffing for the Exchange; market research, outreach and marketing; and consumer assistance activities.

The results of the Urban Institute's Health Insurance Policy Simulation Model were summarized. This modeling was used to estimate the impacts of health reform implementation in New York, including estimated Exchange enrollment and effects on premiums in both the individual and small group markets at full implementation of the ACA. Approximately 1.1 million New Yorkers are expected to gain coverage through the Exchange. Both individual and small group premiums are expected to decrease. Individuals and small businesses will receive an estimated $2.6 billion per year in federal tax and cost sharing subsidies and New York will receive increased federal Medicaid match estimated at $2.3 billion per year for those newly eligible for Medicaid and approximately 800,000 childless adults currently covered by NYS Medicaid.

The panel described the status of policy studies underway on New York's Exchange along with an update on the information technology (IT) contract with Computer Sciences Corporation to develop IT tracks for eligibility and enrollment, plan management, customer service, SHOP, finance and reporting. The panel then reviewed the implementation timeline for the Exchange to seek federal approval, which includes accepting applications from individuals and small businesses on October 1, 2013 for coverage effective January 1, 2014. The thirteen Blueprint requirements were described for Committee members. Based on these thirteen categories, eight policy issues were identified for discussion at this series of Regional Advisory Committee meetings: market merger, small group size, reinsurance/risk adjustment, role of producers and navigators, Basic Health Plan, Qualified Health Plan certification criteria, and essential health benefits. The policy questions and background information follows, along with the feedback received at each regional meeting.

Market Merger: Should New York merge the individual and small group markets?

- Whether to merge the individual and small group markets and what impact such a merger has on premiums (merger is not required by the ACA)
- Urban Institute modeling results:
  - Without market merger, premiums are estimated to decline in both the small group market and individual markets when reform is fully implemented
  - Merging the markets will result in an additional reduction in individual market premiums and a modest increase in small group market premiums (net decrease overall)

Additional notes: Merging the individual and small group markets would requires a change in NYS law. The timing for this is challenging because plan applications for QHP certification are due in March and rates are due in April; plans need to have certainty regarding market merger in order to prepare their proposals. Under the merged market scenario, an additional 58,000 people would gain insurance as compared with no market merger, according to the Urban Institute Simulation Modeling. Market merger affects markets both inside and outside of the Exchange.

Western NY: There were several clarifying questions around the variables that defined the modeling results. Proponents of a merged market cited lower premiums for individuals as a reason to merge the markets. Small business representatives stated that small employers cannot shoulder more costs. Some hesitation was expressed on the impact on the small group market in the event that enrollment does not materialize as predicted by the model. It was also suggested that the state wait to merge markets to keep things simple in the early stages of implementation and revisit this question in future years.

Central NY/Finger Lakes: Clarifying questions on the model assumptions were answered. Committee members asked whether this issue could be looked at from an upstate/downstate perspective. The Panel pointed out that the decision impacts the entire small group and individual markets across the state and that there is no regional flexibility. Affordability was again cited as a reason to merge markets and further drive down costs for individuals. Sole proprietors will be in the individual market as per federal rule, and steps should be taken to ensure their participation. Small business representatives expressed the need for reduced costs.

Capital District/Mid-Hudson/Northern NY: A number of committee members mostly representing consumer groups voiced support for merging the markets, citing the net savings to individuals, and expanding coverage to as many as possible. Some expressed skepticism about the estimated impact on small group premiums and suggested a "wait and see" approach, in order to not rush into this decision when there are significant changes occurring in the insurance market in 2014. It was suggested that merging the markets may cause small businesses to exit the market.

Long Island: There were clarifying questions on the premium reductions cited in the Urban Institute modeling. Several consumer and labor representatives advocated for market merger, saying that the small decrease in net savings to small business was worth the more substantial decline in premiums for individuals. It was also suggested by producer representatives to keep risk pools separate out of the gate. Some concern was expressed by health plans over the Urban Institute's premium estimates. Plan representatives also suggested that small businesses may direct employees into the individual market if costs are not contained.

Metro NYC: Many Committee members, including consumer advocates and providers, supported the concept, citing a more "pure" market and the financial benefit to individuals. Others expressed concern, again, that the small group market might divert employees to the individual market. Some committee members noted there is potential for confusion by doing this now. Some business representatives and producers communicated concern over sole proprietors being in the individual market as they

potentially will lose the benefit of small group purchasing. In response, panel members reported that an analysis shows that the majority of sole proprietors will benefit from individual tax credits when they purchase through the individual Exchange.

Group Size:
Should New York expand small group size from 50 to 100 in 2014?

- From 2014 to 2016, states have the option of allowing small employers of 2-50 or 2-100 to purchase through the Exchange. In 2016, Exchanges must increase small group size to 100
- Urban Institute modeling results: group size definition impacts the size of the Exchange and outside markets, but there are no significant premium or coverage differences

Additional Notes: Expanding small group to 100 requires a change in NYS law. Again, the timing for this is challenging because plan applications for QHP certification are due in March and rates are due in April; plans need to have certainty regarding group size definition in order to prepare their proposals. Under the expansion, employers from 51 to 100 would transition to community rating.

Western NY: Concern was raised about expanding group size to 100 before the federally required date as it would add uncertainty to the market. Questions were asked about whether changing group size would impact mental health parity. The Panel responded that federal mental health parity applies regardless of the size of the group, so there would be no impact.

Central NY/Finger Lakes: Several Committee members spoke in favor of waiting to expand group size until the required federal deadline. There was support among consumer advocates to expand group size to 100 to allow maximum participation in the Exchange as soon as possible.

Capital District/Mid-Hudson/Northern NY: Sole proprietors were clarified as being required to purchase through the individual Exchange under federal rules. Representatives of insurance producers spoke in favor of waiting to expand group size until 2016. A provider representative spoke in favor of a more consistent marketplace with reduced disruption if group size were expanded now.

Long Island: A point was made to use care in bringing employers of 51-100 into the small group market as it may result in them choosing to self-insure instead. There was brief discussion as to the role of Professional Employer Organizations (PEOs) in the current market.

Metro NYC: Some consumer representatives and health care providers voiced support for increasing group size to 100 in 2014. Again, concerns were expressed that small groups may divert employees to individual market if conditions are not favorable. Committee members asked for more clarification about the rules for counting employees for purposes of determining group size.

Reinsurance/Risk Adjustment: Should New York administer the reinsurance and risk adjustment programs or defer to the federal government?

- States with a state-run Exchange have the option (now or in the future) to administer the risk adjustment and reinsurance programs or have HHS administer them
- Wakely Consulting findings:
  - Most risk adjustment models produce similar results – no clear advantage to one model over another
  - Many insurers are familiar with the federal model used for Medicare
  - Wakely recommends that New York administer the reinsurance and risk adjustment programs, in part, because of the state's experience with risk mitigation programs
  - Whether administered by New York or HHS, insurers would need to calculate risk scores until New York's All Payer Database is operational

Western NY: There was general agreement that the federal model is simpler, more widely used and more familiar to all players in the state. However, at least one health plan expressed support for state administration of risk adjustment.

Central NY/Finger Lakes: Several members encouraged the use of the federal model, and suggested that that the State not reinvent the process. Plan representatives expressed preference for a state model operated under state administration because we will have more control. A few plan representatives said federal risk adjustment model would need to be modified for use in a non-Medicare population.

Capital District/Mid-Hudson/Northern NY: There was limited discussion of this issue here. Some plan representatives expressed a preference for the federal model (citing ability to secure vendor support with this model more easily), but were neutral regarding federal versus state administration.

Long Island: One plan representative supported using the state (CRG) model for the widest possible application, while other plan representatives stated a preference for the federal model.

Metro NYC: A provider representative expressed support for the more familiar federal model, but cautioned that under any model, "gaming" the system by manipulating coding is possible. Consumer advocates urged the State to retain risk adjustment authority on state level, so the risk methods are consistent for commercial insurance and government programs. Some members warned against too many moving parts and urged consideration of those functions that needed to be implemented by 2014 versus those that did not. Others raised the question about the implications of transitioning from a federal to state model in the future.

Role of Brokers and Other Assistors: What role should brokers play selling individual or small group Exchange coverage? Who should compensate brokers – Exchange or insurers? What role should Chambers, Associations play?

- Wakely Consulting findings: 88 percent of NYS small group coverage is sold through producer; important distribution channel for the Exchange to retain
- Most insurers do not offer commission for individual market sales; as such, compensating producers for selling individual Exchange coverage would be a new system cost
- Producer commissions in small group market range from 2 to 6+ percent; HMO commissions are capped at 4 percent; DFS can regulate producer compensation
- Commission payments could be made by the Exchange or insurers; insurer payment would leverage existing infrastructure while Exchange payment would add an administrative layer
- Chambers and business associations provide valuable contact points for small businesses; experience/interest varies: some have producers' licenses, others may prefer to apply as Navigators

Western NY: Some Committee members suggested movement away from a percent of premium compensation model to a new commission methodology. They also expressed that lessons can be learned from Massachusetts which did not allow producers to distribute MassConnector products in the early years. Several members commented that there must be parity on commission structures both inside and outside the Exchange.

Central NY/Finger Lakes: Again, members suggested that New York look at the early experience of Massachusetts. Several agreed that the current model of insurers compensating producers should be left intact. Others discussed the important role producers have in advising sole proprietors.

Capital District/Mid-Hudson/Northern NY: A Committee member representing a Chamber of Commerce described the role that Chambers currently have in serving sole proprietors and urged that it continue. Producer representatives offered that insurers should continue to compensate producers. Again, parity on commission inside and outside Exchange was described as crucial. Medicare Advantage was suggested as a model for commission structure for individuals. Some suggested that producers should serve small businesses and sole proprietors, while navigators should serve others in the individual market.

Long Island: Some members voiced the importance of separating the role of producer and navigator to minimize confusion for consumers. Some producers suggested that they could serve the individual market effectively. It was stated that insurers should continue role of compensating producers. The importance of transparency in commission method was stressed. Producers will need to be trained and ready. Long Island Alliance experienced increased success once they put producer commission on par with industry.

Metro NYC: Producers said they are often called by individuals for assistance; they are restricted on individual sales currently. It was stated there may be a place for producers in all areas of the Exchange. The Small Business Assistance Program managed by Community Service Society of New York (CSS) was touted as a good model for small group market support. A consumer member said that conflict of interest standards, training standards, and certification requirements for all assistors is critical. Another noted that health literacy must be prioritized. Again, producers pointed out that they can effectively serve sole proprietors in individual market. They advised the use of all existing channels of distribution. Business associations expressed a need for all assistors to be well-versed in order to help people understand all their options. Finally, a plan representative urged attention to the cost implications of these decisions and that we not add new system costs where it is not needed.

Third Party Assisters
How should New York design the Navigator program to best assist consumers?

- Exchanges must have a Navigator program to assist consumers; must provide in-person, culturally competent, linguistically appropriate, and disability accessible, application and enrollment assistance to consumers
- Federal law and rule require states to make certain choices in selecting Navigators: certification criteria, conflict of interest standards, training standards
- Navigators cannot receive compensation directly or indirectly from insurers
- New York has a strong foundation to build upon, including: facilitated enrollers, Local District Offices, Community Health Advocates
- Federal grant funding cannot be used to pay Navigator grants; but can be used to pay "in-person assisters"
- Ideally the Navigator program will be operational prior to Oct 2013 open enrollment
- Empire Justice Center/Community Service Society report (Sept 2011)

At the Committees' request, the Exchange secured the following additional guidance from HHS: 1) confirmed that Tribal Nations are permitted to be Navigators, so long as the Navigators are in compliance with the Conflict of Interest standards in the federal regulations and the Conflict of Interest policy that will be developed by the Exchange; 2) HHS will determine whether school based health centers or other providers are eligible to apply for Navigator grants; and 3) plan-based facilitated enrollers that are not certified QHPs are not eligible to be navigators as per federal regulation.

Western NY: The Panel clarified that the number of grant awards is TBD. The Department of Health's Facilitated Enrollment (FE) program was pointed to as a reliable and effective model to expand upon. The Exchange will seek additional guidance on school-based health centers as navigators. Navigators must be prepared for high volume initially and that the Exchange should use the program to collect good data. It was advised to create a system where navigators and producers cross-refer.

Central NY/Finger Lakes: Navigators must be sensitive to local and cultural influences and have access to language interpretation including ASL, use different methods of training (e.g., webinar and in-person). The Community Health Advocates (CHA) was pointed to as a good model. Materials must be compelling and easily accessible. Many organizations expressed interest in Exchange educational materials ASAP.

Capital District/Mid-Hudson/Northern NY: The Panel clarified that the number of grant awards is TBD. It was also clarified that federal conflict of interest rules preclude providers/hospitals that accept insurance reimbursement from seeking navigator grants. Again, CHA was pointed to as a good model. Consumer representatives said that the community-based organization model for navigators is important, and that producers and navigators can complement one another.

Long Island: Role between Producers must be clear. The FE and CHA models were pointed to as effective systems to reach low income, vulnerable populations. Committee members noted Long Island has high needs in terms of transportation and language access and emphasized the need for up-front training to meet demand. Consumer advocates expressed a need to keep producer and navigators separate to minimize confusion.

Metro NYC: Many consumer representatives and others voiced support for the community-based model of assistance, with specific reference to CHA. With very diverse populations in NYC and beyond, some said it will take many and multiple types of navigators to serve the Exchange population and that services must be culturally competent and language accessible. Hospitals, providers and unions all would welcome the enrollment/navigation model to apply to their organizations but would need proper training. Medicare transitions and appropriate outreach must be considered. It was pointed out that the

Exchange will serve many who are new to insurance and are unfamiliar with working with producers; therefore the Exchange must have comprehensive networks of support. Some warned that the Exchange ought to be prepared for high-up front volume. Others noted while the Exchange needs to adhere to the "no wrong door" standard, it should avoid multiple access points to eliminate duplication.

Basic Health Plan: Should New York offer the optional BHP?

- ACA allows states the option to create a new program for low-income individuals up to 200 percent of federal poverty who are not Medicaid eligible; states have flexibility on benefits and cost sharing and will receive 95 percent of federal Exchange subsidies
- Urban Institute Findings:
  - Estimated enrollment: 468,000
  - Exchange size declines from 1.1 million to 820,000
  - Advantages: potential for $600 million annual State savings, increased affordability for consumers, and improved continuity of coverage
  - Disadvantages: concerns about access to care because provider payment rates may be below commercial rates, potential impact on the Exchange due to adverse selection impact on premiums, reduced negotiating leverage with plans
  - Uncertainties: calculation of the federal payment is uncertain pending federal guidance

Additional notes: Creation of a Basic Health Plan (BHP) in New York may require statutory authority.

Western NY: Clarifying questions on BHP benefit package were answered. The panel said the Urban Institute found that the impact of BHP on Exchange premiums would be minimal. Behavioral health representatives expressed concern about high cost or inadequate benefits for behavioral healthcare. Some felt BHP was an important program to catch those who often fall through the cracks. Others noted the State needs to design a system that minimizes churning and enhances continuity.

Central NY/Finger Lakes: Members emphasized that BHP can only be successful with adequate provider network, noting that there is already a scarcity of PCPs in CNY, regardless of reimbursement rates. The panel clarified that the state's definition of Essential Health Benefits will apply to the Basic Health Plan and specifically clarified in response to a Committee member's question that chiropractic benefits will be included.

Capital District/Mid-Hudson/Northern NY: Providers and hospitals expressed concern over low reimbursement rates which may deter participation. The Panel clarified that the Urban Institute's BHP model was run on Medicaid and Medicaid +25% rates. In response to a question from a Tribal Nation representative about residency requirements for coverage, the panel clarified that current residency requirements for coverage still stand in this product. Advocates said how important this product is for low income residents, especially those with fluxuating income. Others noted that those with serious mental illness don't fall through the cracks with this option.

Long Island: In response to Committee members' questions, the panel confirmed that the premium impact of BHP on the Exchange is minimal. Members noted that provider adequacy will depend to some extent on reimbursement rates. Many were supportive of the BHP concept.

Metro NYC: The value of BHP was expressed by many, who noted the benefits are compelling and the fiscal benefit to the state is attractive, and to focus on minimizing the disadvantages. The target population may go uninsured otherwise. Members noted home care workers and hospital aides would benefit from this plan option. Providers suggested that low reimbursement rates will deter participation. The Panel clarified that BHP will be a managed care delivery system and will involve a contractual relationship with providers. The Panel offered to clarify the default rate for BHP, which was raised as an area of concern by health plan representatives. A FQHC representative raised the need for their priority populations to be adequately covered at appropriate rates.

Qualified Health Plan (QHP) Certification: Should New York impose additional, state-specific criteria for QHPs? What should these be?

- Federal minimum standards for QHPs:
  - Be licensed and in good standing
  - Comply with Exchange procedures, processes and requirements
  - Offer products that are in the interest of qualified individuals and qualified employers
  - Adhere to: Financial Management Standards (i.e., risk adjustment and reinsurance), Enrollment standards, Network Adequacy Standards, Essential Health Benefits Requirement
  - Meet Reporting requirements (i.e., quality improvement reporting, prescription drug reporting, enrollment reports), Marketing Standards (i.e., notice requirements and plain language standards), requirement on segregation of abortion funds, Transparency Requirements
  - Gain accreditation within the timeframes established by the Exchange
- States can impose additional criteria on QHPs, including:
  - Requirements to ensure options available in all regions, AV tiers, Individual/SHOP
  - Whether benefits offered to individuals and small groups should be standardized inside the Exchange, or inside and outside the Exchange (not required by the ACA)

Western NY: Suggestions included minimum standards on consumer protections like appeals and data collection on health disparities. Some noted there is a need for more competition in rural markets. One member noted that the standard plan in the MassConnector has been very successful, while another said that non-standard plans will help spur innovation.

Central NY/Finger Lakes: Plan representatives expressed concern that too many requirements on plans will drive up prices. Provider infrastructure is a huge challenge. Consumer advocates suggested that QHPs be given criteria on health disparities. On standardized benefits, business representatives said a core set of standard plans with options for variety is good. Plan representatives pointed out that more non-standard plans lead to more adverse selection. The Panel clarified that the catastrophic plan is only available to those under age 30 and is below bronze actuarial value (AV) level. Plan and business representatives said that some employers will divert employees to the individual market if plans are unaffordable; they must be able to find good plans in the AV tiers that they currently offer to avoid dissatisfaction.

Capital District/Mid-Hudson/Northern NY: Advocates asked that QHPs be asked to track health disparity data. Whatever additional requirements are placed, state must be vigilant in surveillance to enforce the requirement. Concerns were raised about network adequacy in the North Country and elsewhere – not a result of poor rates per se, but of lack of providers. The State was asked to consider having Nurse Practitioners allowed as providers. There was support for standardized benefits, saying that it is important to minimize variation because too many products would test customer service infrastructure. Too many plans also drain provider resources, and choices must be clear and manageable to consumers. Producers expressed the value in innovation that comes with non-standard plans, and argued that focus group testing will be necessary.

Long Island: Providers stated that managing too many plans imposes costs on provider community. The Long Island Alliance felt they were stagnant early on with standard plans and that non-standard plans created more interest. Providers expressed concern about the definition of network adequacy, and suggested that an out-of-network benefit will be important. Several voiced support for a hybrid approach. Advocates implored the state to keep options simple and clear. One Committee member pointed to the simplicity in the 10 standard Medicare Advantage plans.

Metro NYC: The importance of data collection requirements on QHPs was highlighted, with a member noting they must be thought through in advance, (i.e. disparities, quality and patient experience), as there seems to be a lack of continuity in this area. One member advocated for leniency on QHP certification criteria for COOPs since they are start-ups. Providers expressed interest in out-of-network benefits that are based on Fair Health. Advocates pointed out that for many consumers, they are looking for a choice of providers, not plans; therefore more standardization is better. Others suggested that more choice can be made available to consumers through policy riders. Another member stated the Exchange must manage a standardized portfolio to avoid adverse selection, but leave room for innovation.

Essential Health Benefits: Which benchmark plan option to select that balances desire for comprehensive benefits and affordability?

- 10 ACA required benefit categories and 10 benchmark plan options *(see original PPT for lists)*
- If a state selects a benchmark plan that includes its state mandated benefits, these benefits are by **definition included in EHB and there is no additional cost to the State**
- This process will be revisited for 2016
- Milliman Analysis
    - Understand the potential overlap of benchmark plans with current state mandated benefits
    - Identify which services are:
    - Consistently covered by all the benchmark plans
    - Covered by all plans but with varying limits, such as annual visit limits
    - Excluded by some plans but covered by others and/or
    - Required by ACA but not covered by any benchmark plans
    - Evaluate the expected cost differential between benchmark plans for the above categories
- Findings: *(See original PPT for accompanying charts)*
    - None of the 10 benchmark options meet all ACA EHB requirements
    - State plans include all state-mandated small group market benefits and many individual market benefits
    - Selection of benchmark plan options would increase costs for small groups by 1.17 to 4.39 percent

Additional notes: Essential Health Benefits apply to all non-grandfathered individual and small group plans inside and outside the Exchange. A decision on Benchmark Plan selection is due to HHS by October 1st.

Western NY: Some Committee members suggested a waiver to offer a plan with slimmer benefits than the EHB. The Panel clarified that the EHB constituted the minimum benefits as required by law. Some supported the lowest cost benchmark option. Small Business representatives noted the cost to businesses is the number one concern. Consumer advocates stressed that consumers deserve a more comprehensive benefit package, arguing that there will be a financial impact for those who have to pay for services that are not covered.

Central NY/Finger Lakes: Consumer advocates voiced support for the Empire Plan. Plan representatives countered that a mandated benefit package that is richer than typical small group coverage will result in an uproar, therefore the State should pick a plan that resembles typical small group plans. Some expressed concern about choosing a plan that does not include adult dental. Several warned that everyone ends up paying for what is not covered in the form of financial distress or charity care. A Committee member emphasized spine care and chiropractic services as cost-saving services.

Capital District/Mid-Hudson/Northern NY: Consumer representatives voiced support for the Empire Plan as the most comprehensive option and urged consideration that the broader estimates of the impact of reform in NY predict premium reductions to individuals and small groups. Other representatives voiced support for a low-cost benchmark plan option. A producer representative reiterated the panel's comment about the cost impact to small businesses: that these costs add up when you consider 50 employees and an average contract size of 2.1. A few clarifying questions about the methodology in the Milliman analysis were answered. Providers asked that all caps be evidence-based.

Long Island: Support was articulated for Empire Plan and adult dental coverage. Others echoed the importance of dental and vision care, especially for aging workers, and lack of attention to these services mean higher costs for employers down the road. Providing coverage for these services will keep costs down long term. The panel clarified that all benchmark plan

options in NY include nursing home, hospice and palliative care services; that we can only select a benchmark from the ten choices and it must contain all ten ACA-required benefit services; and that there is no option to offer a "benefit–light" product. It was clarified that while dollar limits are no longer allowed under federal law, benefit limits from the benchmark plan carry over as the new minimum. A provider representative urged caution that vision benefit not be driven at the retail level, which may not fulfill EHB requirement. Producer representatives expressed that affordability is key.

Metro NYC: A plan representative asked how the State can reduce costs even further, advocating for a reduced benefit option as well as consideration of delivery system reforms to realize cost savings. Advocates expressed support for the Empire Plan and discouraged a more bare-bones approach. Others argued that affordability is a critical threshold question because many will go uninsured if prices are too high. Business representatives in particular advocated for affordability considerations, and reiterated the importance of the Exchange starting out with rates as affordable as possible to encourage participation. Further, they indicated that small businesses are "capped out" and will pass new costs to employees. Other Committee members argued that limiting benefits will result in higher costs later (e.g., limiting physical or occupational therapy would result in more hospitalizations). Another noted the system's current problems will not go away with a limited benefit package.

Next Steps:

Committee members were asked to submit suggestions for future meeting topics. Suggestions included the SHOP Exchange, quality and satisfaction ratings, Medicaid benchmark benefits, Exchange self-sufficiency, IT systems development and demonstration, tools for outreach and education, and network adequacy.

The Exchange staff set forth several options for future meetings including web-based meetings to demonstrate online modules, as well as combining in-person regional meetings for common agenda discussions.

Committee members can expect to receive frequent communication from the Exchange staff including opportunities to comment on consultant reports and policy proposals, current news regarding Exchange planning, and meeting details.

Finally, members were given several ways to contact staff at the Exchange and were encouraged to submit any additional comments and suggestions on the topics that were discussed to:

Sherry Tomasky
Health Benefit Exchange
NYS Department of Health
518-473-4020
ExchangeRAC@health.state.ny.us