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Community Service Society | Fighting Poverty Strengthening New York

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Community Service Society of New York
Testimony Before
the New York State Department of Insurance
Regarding a New York State Health Insurance Exchange

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The Community Service Society of New York (CSS) thanks Governor Andrew Cuomo and the New York State Departments of Health and Insurance for holding public forums to permit stakeholders to present ideas on the establishment of a Health Insurance Exchange in New York State.

CSS is a 168-year-old 501(c)(3) non-profit dedicated to fighting poverty and strengthening New York. The organization pioneers innovative programs and encourages policy reforms that promote self-sufficiency and create a stronger, more inclusive democracy. CSS recognizes that comprehensive health reform is essential to building strong, economically secure communities and alleviating barriers to employment. To this end, in 2008 CSS co-founded Health Care for All New York (HCFANY) and is proud to house this vibrant health reform coalition. For more information about HCFANY, please visit www.hcfany.org.

New York State Must Enact Exchange Legislation this Session

New York, long a State leader in health care coverage and consumer protections, must act urgently to avoid falling behind other states in establishing the framework for its Health Insurance Exchange, pursuant to the Affordable Care Act (ACA). Already, California, Colorado, Hawaii, Maryland, Washington, West Virginia, and Vermont have moved out in front, and Connecticut and 17 other states have bills pending in their statehouses. New York must act quickly to enact a law which establishes the governance and structure of New York's Exchange and identifies a process for making important decisions, many of which are described below.

New York must enact Exchange legislation during this Session for two reasons. First, five years' worth of federal funding to essentially finance the establishment of our State's Health Insurance Exchange will be jeopardized if we fail to act. States with enacted Exchange governance statutes are eligible for hundreds of millions dollars of federal underwriting through

Level II Exchange Establishment Grants, offered by the U.S Department of Health and Human Services. While New York can immediately seek a *de minimus* one-year term Level I grant, forgoing a five-year Level II grant is a risky move. Already, the U.S. House of Representatives has passed budget legislation revoking this funding opportunity. New York should not gamble with the uncertainties of the federal budget process. In short, we should pass an Exchange bill now and quickly file for Level II funding which would underwrite most, if not all, our Exchange establishment costs.

Second, a number of complex health policy, insurance and financial issues must be resolved before the Exchange becomes operational in the summer of 2013. These decisions require extensive study and consultation with a number of stakeholders. They include, but are not limited to: merging the small group and individual markets, the role of the Exchange as an active purchaser, the interaction between public and private health plans, the role of brokers, navigators and consumer assistance programs, benefits design, maintenance of mandated benefits, and the achievement of health equity.

Key Issues that New York Should Address in its Exchange Statute

The Exchange Should be a Governmental Entity

New York should house the Exchange in an existing governmental department or a public authority. A governmental entity is more likely to be trusted by the general public in handling complex data matches of tax, social security and other confidential information for which the general public has a general expectation and demand for maximum privacy and security. Moreover, a governmental entity will be required to be accountable to the public and follow transparent purchasing, hiring and policy-making procedures. By contrast, a not-for-profit entity will not have governmental accountability or transparency and would not be trusted by the general public with making adjudicatory decisions or handling confidential information.

Over the past few weeks, it would appear that a consensus appears to be coalescing around the idea of a public authority. HCFANY is supportive of this consensus position as it would yield some significant advantages, including enhanced flexibility in procurement and other rules, singularity of mission, and freedom from conflict of interest between regulatory and contracting roles.

The Board Should be Composed of State Regulators and Independent Fiduciaries

CSS recommends an Exchange Board governance model in which the Board has seven members, appointed by the Governor, upon advice and consent of the Legislature. In New York, the ideal Exchange Board would have:

- Three Ex Officio Members that would represent the regulators of the commercial and public insurance industry, namely: the Superintendent of Health Insurance; the Commissioner of Health; and the State Medicaid Director.

- Three to Four Fiduciary Members. These Fiduciary members would represent the interests of consumer and employer purchasers of products offered by the Exchange, might also have public health research expertise, and must have demonstrated knowledge and expertise in at least two of the following areas:
    - Individual health care coverage
    - Small group coverage
    - Public Insurance coverage
    - Health plan administration
    - Health care finance
    - Administration of public or private health care delivery systems;
    - Purchasing and/or facilitating enrollment in coverage;
    - Public health and public health research, including expertise on health needs and health disparities in the State's diverse communities.

In addition, these Fiduciary members of the Board should reflect a diversity of expertise and also reflect the gender, racial and ethnic and geographical diversity of the State.

The Board Must be Bound by Strong Anti-Conflict of Interest provisions.

Importantly, the Fiduciary members must be bound by strong anti-conflict of interest rules including:

- No financial interest under New York law;
- No affiliation with a carrier, a producer, a third-party administrator, a managed care organization, or any other person directly contracting with the Exchange; and
- No affiliation with any trade association of carriers, insurance producers, third-party administrators or managed care organizations or any other association of entities in a position to contract directly with the Exchange.

The Board Should Establish an Advisory Committee which Represents Stakeholder Interests

Finally, the Board should establish an advisory committee that takes into account the views and knowledge of stakeholders who might be precluded from Board service by their conflicts of interest and to more fully represent the diverse interests of New York's stakeholders. Membership should include:

- Commercial insurers carriers;
- Non-profit health plans;

- Licensed health producers and advisers;
- Third-party administrators;
- Health care providers, including: (Hospitals; Long-term care facilities; Mental health providers; Development disability providers; Substance abuse treatment providers; FQHCs; Physicians; Nurses; Experts in services for juvenile justice; Licensed hospital providers; and other health care professionals;
- Employers;
- Unions;
- Consumers, including those who:
    - Represent low-income consumers and/or racial or ethnic minorities
    - Have chronic diseases or disabilities; or
    - Belong to other hard-to-reach or special populations;
- Individuals with knowledge and expertise in advocacy for consumers described above;
- Public health researchers and other academic experts with knowledge and background relevant to the functions and goals of the Exchange, including knowledge of the health needs and health disparities among the State's diverse communities; and
- Any other stakeholders identified by the Exchange as having knowledge or representing interests relevant to the functions and duties of the Exchange.

A Single, State-Based Exchange Would Best Serve New York Health Care Consumers

New York should establish its own single statewide Exchange rather than cede its authority to the Federal Exchange. Our State has long been a leader in providing access to affordable, high quality public health insurance to its low-income residents (e.g. Child Health Plus, Family Health Plus and other programs) and affording strong consumer protections to those who have private insurance. Our unique market features and regulatory framework can best be maintained when a single state-controlled Exchange is overseeing the new coverage mandated by the Affordable Care Act (ACA).

A single statewide Exchange will serve two important aims: increasing purchasing power and pooling risk. Currently, New York has 2.6 million uninsured residents. As the table below displays, the best estimates indicate that anywhere between 700,000 and 1.2 million New Yorkers would use the Exchange to seek coverage—not counting the hundreds of thousands of New Yorkers who could possibly use the Exchange as a gateway to public coverage.

The ACA and Coverage in New York

	Currently Uninsured	% of Total Uninsured	Newly Insured Post-Reform	Remaining Uninsured Post-Reform
Eligible for Medicaid but unenrolled	1,000,000	42%	110,000-440,000	660,000–1,000,000
Newly eligible for Medicaid (Childless adults 100-133% FPL)	90,000	3%	50,000-70,000	20,000-40,000
Access to Exchange & Eligible for Subsidies (0-400% FPL)	700,000	27%	570,000	130,000
Access to Exchange & Not Eligible for Subsidies (>400% FPL)	340,000	13%	80,000	260,000
Affordability Exemption Takers				200,000
Penalty Payers				60,000
Undocumented Immigrants	390,000	15%	0	390,000
TOTAL	**2,620,000**	**100%**	**810,000-1,160,000**	**1,460,000-1,820,000**

Source: "Implementing Federal Health Care Reform: A Roadmap for New York," NYS Health Foundation (August 2010).

Over one million New Yorkers are estimated to be eligible to purchase coverage in the Exchange as individuals. Some will be eligible for subsidized coverage (around 700,000 New Yorkers with incomes up to 400 percent of the federal poverty level), while others will directly purchase coverage at full prices. Individual responsibility rules may also motivate small business employees to enroll in group coverage. That effect, plus growing small employer awareness of tax subsidies for providing coverage to their employees, is likely to cause the small group market to grow beyond its current enrollment of approximately one and one half million lives as well. Many of these small groups will want to purchase coverage in the Exchange.

Setting up regional Exchanges throughout the state – two or more separate Exchanges to cater to different areas of the state – would be a step in the wrong direction for New York. This would allow the state's market share and risk pool to be attenuated, limiting the ability of the Exchanges to negotiate with insurers, and potentially increasing the effects of adverse selection in certain areas of the state. The most vibrant Exchanges should have over 100,000 covered lives

to adequately pool risk. (A. Enthoven et al, "Making Exchanges Work in Health-Care Reform," Committee for Economic Development, December 14, 2009.)

In addition, segmenting the markets offered in the Exchange would impede unnecessarily the sort of uniform data collection by the Exchange that can lead to cost savings and addressing health disparities. Finally, we know from the public insurance context that multiple jurisdictions lead to a multiplicity of rules and a lack of uniformity, resulting in processing delays, disruptions in coverage and other seriously harms to consumers. (New York State Department of Health, "Medicaid Administration November 2010 Report.")

To address regional needs, New York's Exchange can adopt regional pricing and outreach models. For example, New York regulators routinely adjust for regional health cost differentials by establishing regional pricing in both the private and public insurance contexts. Similarly, localized outreach functions can be best addressed by a well-run Navigator program, discussed in greater detail later.

With hundreds of thousands of participants, a New York Exchange should have a significant market power to help bring down prices for the people who use it. A single statewide exchange, which spreads risk across a large group of people, will help bring down prices for all.

New York's Exchange Should Merge the Individual and Small Group Markets and Pool Risk Inside and Outside the Exchange to Maximize Affordability of Coverage for All

The Exchange should maximize its purchasing power and risk spread by merging the individual and small group markets. Between 2000 and 2009, health insurance prices have increased by 92 percent, while median wages only increased by 14 percent during the same period. And prices in the individual, or direct pay, market, are beyond most people's means: the statewide average is well over $1000 per month (or over $24,000 a year for family coverage). Faced with such prices, only the very sick or the very wealthy have the incentive or the wherewithal to acquire this coverage.

The ACA's individual mandate means that many more healthy individuals will be joining the individual market. However, we anticipate that a great many of those will concentrate in the lowest benefit, lowest premium policies. The most comprehensive policies that attract those with serious and chronic illness may continue to attract very few individual purchasers who do not have employer subsidies. To ensure that individual purchasers have meaningful access to a full range of insurance products, New York should follow Massachusetts' lead and merge the individual and small group markets.

A study commissioned by the United Hospital Fund three years ago found that prices in the individual market would decline as much as 38 percent as the result of a merger, while prices

in the small group market would increase by a mere two percent. (United Hospital Fund, "Merging the Markets: Combining New York's Individual and Small Group Markets Into Common Risk Pools," 2008). Today, when the individual market has shrunk significantly from its 2008 size and prices have increased dramatically, the savings to direct pay consumers would likely be higher and the effects on small groups may be even more minimal. In addition, actuaries believe that should New York increase the legal size of its small group market from 50 to 100 employees, as permitted under the ACA, both current small groups and individuals would incur significant savings. Under the ACA, market mergers and expansions to 100 employees are permitted. New York should take advantage of this opportunity.

Risk should be also be pooled between plans operating inside and outside of the Exchange. Section 1343 of the ACA requires the Secretary, in consultation with the states, to establish a permanent risk adjustment program for all plans in the individual and small group markets as a means of leveling the playing field among plans. States, such as New York, which currently use multiple risk adjustment mechanisms (e.g. CRGs, Regulation 146, reinsurance) should consider utilizing one risk adjustment mechanism for public and private plans. Using one mechanism would bring significant benefits to the state, including administrative cost savings, better continuity of coverage for enrollees, and a greater predictability of health costs for rate setting in the public market and prior approval of premium rate increases in the private market. (D. Bachrach et al "Medicaid's Role in the Health Benefits Exchange: A Roadmap for States," National Academy for State Health Policy, March 2011). The risk adjustment mechanism adopted by New York should be administratively simple and designed to give support to plans suffering adverse selection on the fastest schedule possible.

In addition, New York should strongly consider creating a Basic Health Plan under Section 1331 of the ACA. Not only would this move generate significant State savings, it would ensure quality affordable coverage to low-waged families and individuals. The risk of these Basic Health Plan enrollees (who are barred from purchasing coverage in the Exchange) should be pooled with the individual and small group markets. (S. Dorn, "The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States," Academy Health, March 2011).

The Exchange Should be an Active Purchaser

The Exchange should also maximize value and consumer protections for New Yorkers by assuming the role of active purchaser. While the ACA lays the groundwork for the Exchange's regulatory functions, it leaves the states with significant flexibility on the extent to which these regulatory functions may be pursued.

New York should *not* play a passive role in the regulation of participating plans by implementing the bare minimum regulations and taking on a "free market"-style approach, or adopt the Utah model, as some suggest. (The Manhattan Institute, "Building a Market-Based Health-Insurance Exchange in New York," 2011). The appeal of the concept of the Exchange is that it creates market bargaining power, through aggregation, for the individuals and small businesses that traditionally had none. Failure to put that market power to use constitutes a failure to realize the potential benefit of the Exchange. It is important to understand that the Utah Exchange merely covers a few thousand lives, and accordingly, has almost no market power. By contrast, New York's Exchange would cover hundreds of thousands of New Yorkers.

With significant numbers of Exchange beneficiaries, our State has a crucial opportunity to curb insurance costs and simultaneously improve quality and promote health equity. New York's Exchange should leverage its market share and utilize an aggressive bidding process, or actively negotiate with plans to ensure that consumers receive the highest value for their money.

New York Should Establish a "No Wrong Door" Policy for its Exchange

The ACA requires Exchanges to inform individuals of the eligibility requirements and enroll them in Medicaid, CHP, or any other state or local public program. (ACA Section 1311(d)(4).) This will ensure a "one-stop shopping" experience for consumers and individuals eligible for public coverage who seek coverage on the Exchange will be much less likely to fall through the cracks.

Public coverage and the subsidized commercial products in the Exchange must be integrated as much as possible. An estimated 50 percent of potential Exchange enrollees will flip from eligibility for public programs to commercial coverage, and back, in any given year. (B. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs*, 30, no.2 (2011):228-236). The Exchange will have to address these transitions as efficiently as possible.

Fortunately, New York has taken important steps towards addressing these kinds of transitions. For example, we have streamlined eligibility systems by eliminating the asset test and face to face applications, and we have established a Statewide Enrollment Center and initiated the critical conversation about eliminating expensive and redundant county-based eligibility systems. But these steps, while important, simply do not go far enough to efficiently administer the ACA.

To realize our goal of "no wrong door," New York should:

- Simplify our eligibility and enrollment procedures for public coverage by radically revising the application for coverage;

- Centralize all eligibility systems, eliminating the Byzantine county-based eligibility system and procedures permanently;
- Adopt the Modified Adjusted Gross Income system for eligibility when the relevant federal guidance is issued;
- Ensure that consumers are able to fully access public and private coverage through comprehensive language and disability accessible services;
- Seek federal permission to use less-than current tax data for eligibility determinations and sampling methodologies to comply with federal quality assurance standards; and
- Ensure that family coverage dates align, regardless of whether individuals in the family have public, subsidized coverage, or a combination of the two.

These steps, and others, will help ensure seamless integration of coverage, benefiting thousands of New Yorkers.

New York State Should Support Strong Consumer Assistance Programs

New York should build on the strong foundation of consumer assistance entities already working in the state to ensure that consumers get the help they need to successfully enroll in coverage, use the coverage they have, address confusion and errors created with new systems, and help consumers access their new rights and protections.

As described above, hundreds of thousands of New Yorkers will be seeking coverage through the Exchange. Many of these families will have mixed incomes, mixed eligibility for different types of coverage, and mixed immigration status. Accordingly, the Exchange must be easy to navigate, offer smart and comprehensive enrollment guidance, and truly represent the interests of consumers. All enrollment information should be simple, easy to understand, available in multiple languages and accessible to people with disabilities. But the Exchange cannot enroll a million New Yorkers by itself. And New York will need to build upon its robust distribution channels for insurance coverage.

Already, New York benefitted from one opportunity created by the ACA to increase consumer assistance capacity for New Yorkers by securing $2.2 million in federal funding for a state consumer assistance program, or CAP. The ACA authorized federal support for states to establish, expand, or support existing CAPs to help consumers understand the new health coverage landscape. CAPs that qualify for this funding are independent agencies or ombudsprograms that perform five basic functions: (1) outreach and education; (2) enrollment assistance; (3) help with filing complaints and appeals; (4) collecting and reporting data to track problems that consumers encounter; and (5) helping consumers obtain tax credits when they become available in 2014. (ACA, PL 111-148, §1002).

In 2010, New York designated the nonprofit Community Health Advocates (CHA), administered by CSS, to serve as the state's CAP. CHA provides education and one-on-one assistance with every aspect of health care coverage, including enrollment and renewal, assistance with problems using coverage, finding access to affordable care for uninsured consumers, and helping with appeals and complaints. In addition to CSS's "hub," CHA has 24 "spokes" that provide boots on the ground to help consumers. Twenty-one community-based organizations around the state serve consumers, with the help of three specialist agencies. Since November 2010, CHA has helped over 3,800 consumers with one-on-one assistance and 4,700 consumers through outreach and education. CHA has helped some consumers to take advantage of new programs and protections created by the ACA, including helping young adults under 26 stay on their parents' coverage, and helping consumers enroll in the NY Bridge Plan.

HHS has encouraged states to fund CAP programs using the multi-year Exchange Establishment grants. If the New York passes Exchange legislation this year, it will secure federal funding to support this critical program through 2013 – yet another way in which passing Exchange legislation this year will benefit New York consumers.

Section 1311(i) of the ACA also requires state Insurance Exchanges to fund a "Navigator" program to: (1) conduct public education to raise awareness on the availability of qualified health plans; (2) distribute fair and impartial information on health plans and subsidies; (3) facilitate enrollment into health plans; (4) provide referrals for consumer assistance or ombudsman services; and (5) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served. The ACA further clarifies that these roles may be filled by any number of entities capable of fulfilling these duties, including health insurance brokers, agents, consumer groups, chambers of commerce, unions, or benefit consultants, provided they are not a health insurance issuer and do not receive any consideration from a health plan in connection with enrollment.

New York can build on the foundation of the state's existing outreach and enrollment assistance providers. Our nationally renowned Facilitated Enrollment program, run by the New York State Department of Health, trains trusted community-based organizations to help individuals enroll in public coverage in the communities where they live and work. With the exception of HealthyNY and some Medicare products, brokers rarely sell individual health policies in New York State. On the other hand, brokers are a trusted source of information for group health coverage. Additionally, brokers play an important "human resource" function in New York's small group market, often helping small businesses with various enrollment and claims issues. The ACA offers an opportunity to better integrate these dual distribution channels.

Navigators will help consumers with both public and private coverage, and will need different training and/or certification than that which Facilitated Enrollers and brokers currently

receive. The Exchange should develop a robust training and certification program, including continuing education requirements, specifically tailored to Navigators. The training curriculum should cover all forms of individual coverage available in New York: public coverage (including Medicaid, Child Health Plus, and Medicare products), Basic Health Plan (if adopted), and individual subsidized and non-subsidized products. All Navigators should be required to participate in this training program, regardless of whether they are licensed brokers or agents. Navigators should not be required to obtain broker or agent licenses to practice as Navigators. Eventually, additional guidance from the federal government will be forthcoming that will guide the conduct of producers who are selling Exchange products and who are helping individuals seeking tax credits. (ACA § 1312(e)).

New York Should Adopt a Universal and Transparent Financing Mechanism for the Exchange

The Exchange should be financed in one of two ways. First, if the Exchange is an independent authority, it could have a taxing authority which would be the beneficiary of a dedicated assessment on all insurance products marketed in New York, including administrators of self-funded plans. This method would generate the broadest revenue steam for financing the Exchange. A second alternative would be to fund it, as we fund many insurance programs and public health initiatives, through existing funding mechanisms, such as the HCRA surcharge on hospital bills or the Section 332 assessment on insurance coverage.

No matter what the source of funding, New York should adopt a universal method of assessment/taxation, applied to products sold inside and outside of the Exchange, so that the maximum amount of funding is generated to ensure a viable Exchange. The reduction in the uninsured that will result from use of the Exchange will benefit all market participants, and should not be funded solely from assessments on sales in the Exchange. The Exchange's financial activities should be transparent and publicly disclosed.

Thank you for the opportunity to submit this testimony. Should you have any questions, please contact Elisabeth Benjamin at ebenjamin@cssny.org or (212) 614-5461.