New York State
Health Benefit Exchange

Regional Advisory Committee
September 2012 Meetings:

Buffalo (9/13)
Rochester (9/14)
Albany (9/19)
Long Island (9/24)
New York City (9/25)

Agenda

- Welcome & Introductions
- The NYS Health Benefit Exchange
- Role of the Regional Advisory Committees
- Background & Timeline
- HHS Exchange Blueprint
- Policy Discussion/Recommendations
- Wrap Up

What the Exchange Will Do in New York

What is an Exchange?

- Organized marketplace
  - Easily compare health plan options
  - Makes available tax credits and cost-sharing subsidies
  - Easily enroll in qualified health plans
- Two programs
  - “Individual Exchange“
  - “Employer Exchange," which is called the Small Business Health Options Program, or SHOP

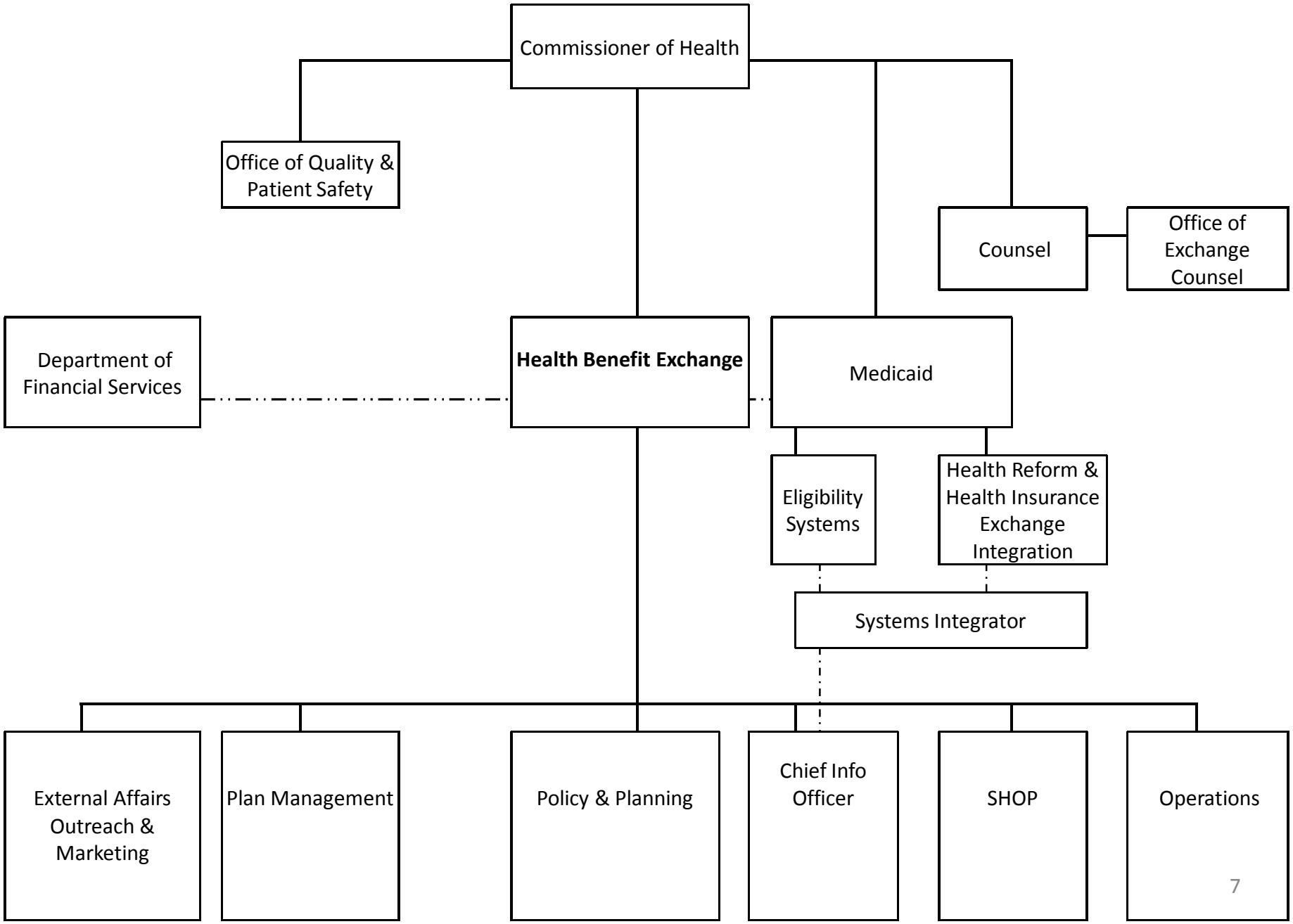
Functions of the Exchange

- Make available qualified health plans and qualified dental plans to qualified individuals and employers
- Assign a quality rating and actuarial value to each qualified health plan offered through the exchange
- Implement certification procedures for qualified health plans
- Require qualified health plans to offer essential health benefits, as determined by federal act
- Provide a toll-free telephone hotline
- Maintain an internet website for questions, enrollment
- Establish electronic means to calculate the actual cost of coverage after tax credits and cost sharing reductions
- Determine eligibility and enroll individuals into a range of coverage options
- Establish Navigator program to assist consumers in shopping and enrollment
- Certify individuals as exempt from individual responsibility

Executive Order 42
Establishing New York Health Benefit Exchange

- Establishes New York Benefit Exchange within the Department of Health
- Directs the DOH, in conjunction with the Department of Financial Services and other state agencies, to take all steps necessary to effectuate the Exchange
- Requires the Exchange to:
  - Facilitate enrollment in health coverage and the purchase and sale of qualified health plans
  - Enable eligible individuals and small businesses to receive federal tax credits
  - Convene regional advisory committees to provide advice and make recommendations
  - Become financially self-sustaining by January 1, 2015 as required by the ACA

Health Benefit Exchange Organizational Chart



Regional Advisory Committees

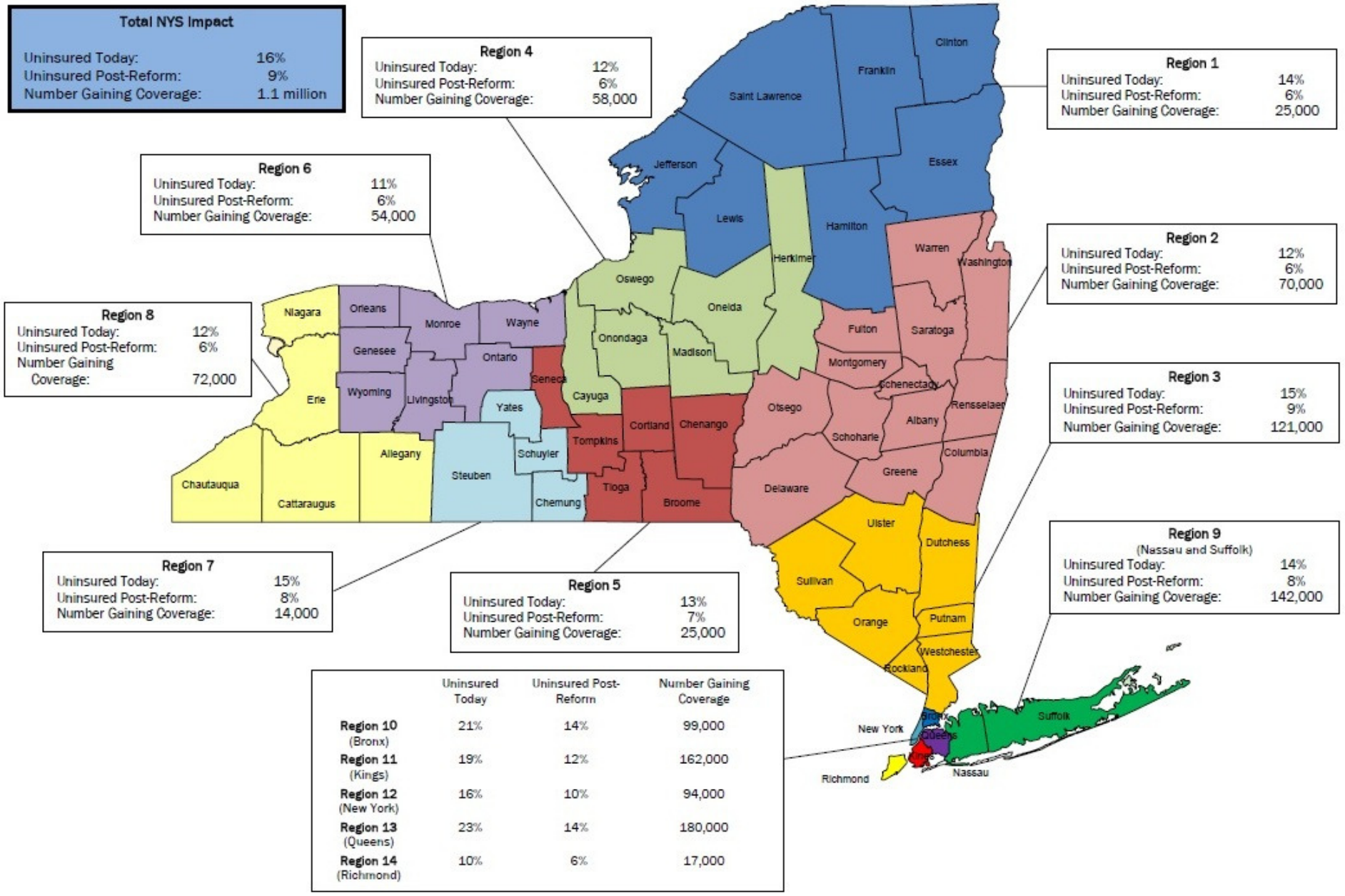
- 175 individuals participating in regional committees to provide advice in the planning and implementation of the Exchange
- Includes consumers, small businesses, health care providers, insurers, brokers, labor and others
- Five regions
  - NYC Metro
  - Long Island
  - Capital/Mid-Hudson/North
  - Central
  - Western

Regional Advisory Committees' Charge

Regional Advisory Committees:

- The core of stakeholder engagement for the Health Benefit Exchange
- The primary vehicle for two-way communication between external partners and the State Exchange team
- Provide advice on key policy decisions
- Provide regional perspective on Exchange issues

Impact of Federal Health Reform on New York's Uninsured

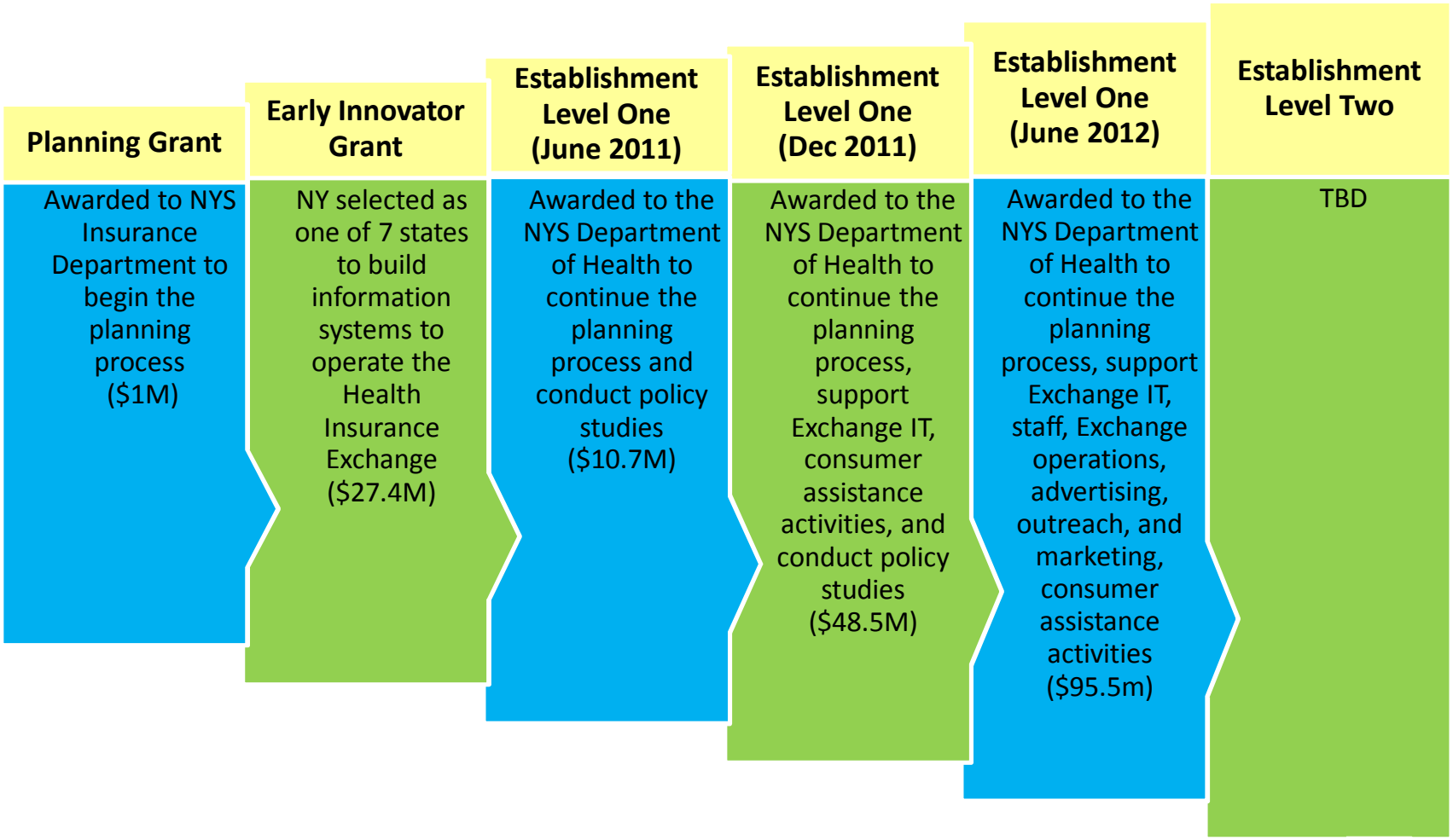


	Uninsured Today	Uninsured Post-Reform	Number Gaining Coverage
Region 10 (Bronx)	21%	14%	99,000
Region 11 (Kings)	19%	12%	162,000
Region 12 (New York)	16%	10%	94,000
Region 13 (Queens)	23%	14%	180,000
Region 14 (Richmond)	10%	6%	17,000

Source: 2009 American Community Survey data and the Urban Institute's Health Insurance Policy Simulation Model. Data include non-elderly persons.

Progress to Date Planning New York's Exchange

New York Awarded Federal Grants to Plan and Implement Exchange



Simulation Modeling: Cost and Coverage Impacts of Reform in New York

- Urban Institute Health Insurance Policy Simulation Model used to estimate the impacts of health reform implementation in New York
  - One million people will gain insurance, reducing the percentage of uninsured from 16 percent to 10 percent
  - Exchange enrollment is estimated to be 1.1 million people
  - Premiums are expected to decline in the small group and non-group markets
  - Individuals and small businesses who purchase through the Exchange will receive $2.6 billion per year in federal tax credits and cost sharing subsidies
  - New York will save $2.3 billion per year when reform is fully implemented as a result of enhanced federal Medicaid support
- Stakeholder meeting held February 2, 2012

Exchange Policy Studies

Study	Consultant	Target date
Simulation Modeling	Urban Institute	Complete
Market Merger & Group Size	Urban Institute	Complete
Basic Health Plan	Urban Institute	Complete
Benefit Standardization	Wakely Consulting	Complete
Reinsurance/Risk Adjustment	Wakely Consulting	Complete
Third Party Assisters	Wakely Consulting	Complete
Essential Health Benefits	Milliman	September 2012
Insurance Markets	Health Management Associates	September 2012
Qualified Health Plan Certification	Wakely Consulting	October 2012
Continuation of State Health Programs	Deloitte Consulting	October2012
Self-Sufficiency	Wakely Consulting	Underway
Medicaid Policy Studies	Manatt Health Solutions Health Management Associates	On-going October 2012

New York Health Benefit Exchange
System Development

- Contract finalized with Computer Sciences Corporation
- Development tracks:
  - Eligibility and Enrollment
  - Plan Management
  - Customer Service
  - SHOP
  - Financial
  - Reporting

New York Health Benefit Exchange Implementation Timeline

- Declaration Letter sent to HHS on July 9, 2012
  http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/nys_declaration_letter.pdf
- HHS Design Review Oct 9-10, 2012
- HHS Exchange Blueprint submission due Nov 16, 2012
- Exchange begins accepting applications on Oct 1, 2013
- Individual and SHOP Exchange coverage effective Jan 1, 2014

HHS Process to Certify State-Based Exchanges

The Blueprint for Federal Approval

- Demonstrate operational readiness to execute Exchange activities

- Submit Blueprint Application:
  - Attest to completion of Exchange activities or dates of expected completion
  - Describe processes and strategies
  - Attach reference files and summaries of results of test scenarios
  - Application process aligns with establishment grant review process

The Thirteen Blueprint Areas

1. Legal Authority and Governance
2. Consumer and Stakeholder Engagement and Support
3. Eligibility and Enrollment
4. Plan Management
5. Risk Adjustment and Reinsurance
6. Small Business Health Options Program (SHOP)
7. Organization and Human Resources
8. Finance and Accounting
9. Technology
10. Privacy and security
11. Oversight, Monitoring and Reporting
12. Contracting, Outsourcing and Agreements
13. Plan Management Agreements

Issues We Are Seeking Your Input On Today

Policy Issues for Regional Advisory Committee Input Today

1) Merger of individual and small group markets
2) Small group size (50 or 100) for the SHOP Exchange in 2014
3) Risk adjustment and reinsurance programs
4) Insurance Brokers
5) Navigator Program
6) The Basic Health Plan
7) Qualified Health Plan certification process
8) Essential Health Benefits

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)

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

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

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 broker; important distribution channel for the Exchange to retain
- Most insurers do not offer commission for individual market sales; as such, compensating brokers for selling individual Exchange coverage would be a new system cost
- Broker commissions in small group market range from 2 to 6+ percent; HMO commissions are capped at 4 percent; DFS can regulate broker 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 brokers' licenses, others may prefer to apply as Navigators

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)

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

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, reinsurance, etc.)
  - Adhere to Enrollment standards
  - Adhere to Network Adequacy Standards
  - Adhere to Essential Health Benefits Requirement
  - Meet Reporting requirements (i.e., quality improvement reporting, prescription drug reporting, enrollment reports, etc.)
  - Gain accreditation within the timeframes established by the Exchange
  - Meet Marketing Standards (i.e., notice requirements, plain language standards, etc.)
  - Meet the requirement on segregation of abortion funds
  - Meet Transparency Requirements
- States can impose additional criteria on QHPs, including:
  - Requirements to ensure options available in all regions, AV tiers, Individual/SHOP
  - Standardized benefits

QHP Certification (continued): Should New York standardize benefits within the Exchange? What is the best approach for doing so?

- 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)
- Wakely Consulting findings:
  - 15,000 plan designs in NYS small group market
  - 48 percent of enrollment falls within bronze, silver, gold, platinum tiers
  - Broad dispersion of plan type (HMO, PPO, POS, EPO)
  - Downstate is more concentrated than upstate
  - ACA requirements – including EHB, AVs, limits on deductibles and OOP maximums – will standardize the market considerably

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

The Basics

- 10 ACA required benefit categories and 10 benchmark plan options
- 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

The 10 Mandated Essential Health Benefits

- Ambulatory Patient Services
- Emergency Services
- Inpatient Care
- Maternity and New Born Care
- Mental health and Substance Abuse Disorder Services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative
- Laboratory Services
- Preventive and Wellness Services and Chronic Disease Management
- Pediatric Services, including Oral and Vision Care

Potential NYS Benchmark Plans Based on HHS Guidance

- Three largest Federal Employees Health Benefits Program (FEHBP)
  - Government Employees Health Association (GEHA)
  - Blue Cross Blue Shield Basic (BCBS Basic)
  - Blue Cross Blue Shield Standard (BCBS Standard)
- Three largest New York State Employee Plans (NYSHIP)
  - Empire Plan
  - Capital District Physicians Health Plan HMO
  - Independent Health HMO
- Three largest New York Commercial Small Group Products
  - Oxford EPO
  - Oxford HMO
  - Oxford Direct
- Largest New York Commercial Group HMO
  - HIP Prime (part of Emblem Health)

Source: December 16, 2011 CCIIO bulletin

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:
    - 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
  - Stakeholder call on March 22 and Stakeholder meeting August 2

Milliman Analysis – Cost Impact Results

- Cost impact to small group plans varies with selected benchmark
- Estimated costs to the current small group market (as represented by the Oxford covered services):

EHB Benchmark	Impact on Gross Medical Costs for Small Group Insurance
FEHBP - GEHA	2.78%
FEHBP - BCBS Basic	2.24%
FEHBP - BCBS Standard	3.19%
Empire Plan	4.39%
CDPHP	4.35%
Independent Health	4.34%
Oxford (All Plans)	1.17%
Largest Non-Medicaid HMO (HIP Prime)	1.24%

Summary of Impact on Gross Medical Costs for Small Groups Assuming Medical Costs of $500 Per Member Per Month

Potential Benchmark Option	Percent Increase in Gross Medical Costs	Per Member Per Month Increase in Gross Medical Costs for Small Groups
FEHBP- GEHA	2.78%	$13.90
FEHBP- BCBS Basic	2.24%	$11.20
FEHBP- BCBS Standard	3.19%	$15.95
Empire Plan	4.39%	$21.95
CDPHP	4.35%	$21.75
Independent Health	4.34%	$21.70
Oxford EPO	1.17%	$5.85
Oxford HMO	1.17%	$5.85
Oxford Direct	1.17%	$5.85
HIP Prime	1.24%	$6.20

EHB Public Comments

- Subsequent to the August 2nd presentation by Milliman, we solicited feedback from stakeholders
- We received comments from over 70 individuals and consumer groups
- Generally, comments fell into five distinct categories:
  - Comments advocating **the selection of a specific plan to be used as the benchmark;**
  - Comments **intended to create awareness of the necessity of coverage for a specific diagnosis/population**;
  - Specific questions/comments about **one or several of the ten plans being considered as potential benchmark plans;**
  - Comments/questions regarding the **Milliman analysis**, and subsequent interpretation of the analysis; and
  - **General comments** regarding the selection of a benchmark plan.

EHB Public Comments – Key Themes

- Importance of comprehensive coverage
- Emphasis on affordability
- Concern surrounding variations in qualitative benefit limits among benchmark plans, such as annual visit limits and courses of treatment available
- Discussion of benefits not commonly covered by benchmark plans:
  - Pediatric dental/vision coverage
  - Habilitative services

Future Issues to Discuss with Regional Advisory Committees

- SHOP
- Medicaid benchmark benefits
- Continuation of existing programs
  - Healthy New York
  - Family Health Plus Employer Buy-In
- Exchange self-sustainability

Additional Information

www.HealthCareReform.ny.gov

Questions regarding implementation can be sent to:
HealthCareReform@exec.ny.gov

Questions specific to the Regional Advisory Committees can be sent to:

ExchangeRAC@health.state.ny.us