American Cancer Society ☙ Children's Defense Fund/New York ☙ Community Service Society of New York ☙
Make The Road New York ☙Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices ☙
Schuyler Center for Analysis and Advocacy

Health Care For All New York
Testimony to
the New York State Senate Standing Committee on Health and Standing Committee on Insurance
Regarding a New York State Health Insurance Exchange

April 27, 2011

Health Care For All New York (HCFANY) thanks the New York State Senate Standing Committee on Health and Standing Committee on Insurance for inviting us to provide testimony about the establishment of a New York State Health Insurance Exchange.

HCFANY is a statewide coalition of over 115 organizations committed to winning quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that real consumer concerns are reflected. We also provide expert policy analysis, advocacy, and education on important health reform issues and policies that affect New Yorkers around the state. For more information on HCFANY, visit us our blog and website at www.hcfany.org.

This year, HCFANY's top priority is to ensure that New York takes concrete steps towards the establishment of a robust, consumer-friendly Statewide Insurance Exchange under the Affordable Care Act (ACA). To this end, HCFANY has adopted five standards for a New York State Exchange to ensure quality affordable health care for all:

1. One Statewide Exchange for All.
2. An Exchange that Offers Quality and Affordable Benefit Packages.
3. An Exchange that is Easy to Navigate and Represents Consumers.
4. An Exchange that Builds on the Success of New York's Public Programs.
5. An Exchange that Supports Principles of Health Equity.

A complete version of HCFANY's Five Standards For a Consumer-Friendly Exchange are attached to this testimony.

Our responses to the Standing Committees questions are below.

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- ***What are the benefits and drawbacks of a State government –sponsored Insurance Exchange versus a Federal government-sponsored Insurance Exchange? If New York State decides to run a State Insurance Exchange, what entity or body is best equipped to administer the Exchange and in what form will the Exchange be rolled out throughout the state (i.e. regional exchanges vs. a singular exchange)?***

A single, state-based Exchange will best serve New York health care consumers. New York should establish its own 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 State controlled Exchange is overseeing the new coverage mandated by the Affordable Care Act (ACA).

A federally-run Exchange would introduce lower standards to New York's insurance market, eroding our robust consumer protections, including our pure community rating law. It would also subject the state to a one-size-fits-all approach to health insurance, denying us the ability to tailor the Exchange to fit the needs of our population. All stakeholders—consumers, insurance industry, providers, policymakers—are unlikely to have sufficient access to federal decision makers, who in turn are less likely to be responsive to conditions in New York. Similarly, a multi-state Exchange would not only potentially erode our strong insurance protections, but it would also lead to a bureaucratic nightmare—with enforcement and consumer protections falling across multiple agencies in multiple states.

A single statewide Exchange will serve two important aims: increasing purchasing power and pooling risk. Currently, New York has 2.6 million uninsured residents. Between 2000 and 2009, median wages lagged seven times behind insurance price increases, a major factor in preventing broader coverage. (Families USA, "Costly Coverage: Premiums Outpace Paychecks," September 2009.)

As a rule of thumb, a viable Exchange needs 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.) Over 1 million New Yorkers are estimated to 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% of the federal poverty level), while others will directly purchase coverage at full prices. Individual responsibility rules may also have the effect of increasing the desire of small business employees for 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. Bifurcation would also impede the sort of uniform data collection by the Exchange that can lead to cost savings and addressing health disparities. Moreover, 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.") New York regulators routinely adjust for regional health cost differential 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, which we will discuss 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.

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).

New York's Exchange should merge the individual and small group markets to ensure affordability for all. 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% as the result of a merger, while prices in the small group market would increase by a mere 2%. (United Hospital Fund, "Merging the Markets: Combing 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 market would likely be higher and the effects on small group 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.

Accordingly, HCFANY urges State policymakers to establish a single statewide Exchange, with a regional pricing structure and with localized enrollment entities (i.e. Navigators, discussed later). The Exchange should maximize its purchasing power and risk spread by merging the individual and small group markets.

- ***How should the Exchange be financed? Is the Exchange a passive body or does it actively negotiate prices?***

New York should adopt a universal and transparent financing mechanism. HCFANY believes that the Exchange could 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, HCFANY urges the Senate to 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 Exchanges financial activities should be transparent and public disclosed.

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 – 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 who 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 these numbers, 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.

- ***What is the status of the Early Innovator grant and how will New York meet the prescribed deadlines?***

  HCFANY defers to the Executive branch to describe the progress on this grant.

- ***What are the roles of health insurance brokers, agents, benefit consultants, and similar actors within the Exchange? Will there be rules and regulations for selling products within the Exchange?***

HCFANY urges New York State to establish a well-funded Navigator program and to comply with federal rules against conflicts of interest. 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. An estimated 50% 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). 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 distributions channel for insurance coverage.

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. The limited scope of Facilitated Enrollers should be expanded to ensure that they are able to enroll people with disabilities and higher income individuals into appropriate public and private insurance options. 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. HCFANY believes that the ACA offers an opportunity to better integrate these dual distribution channels.

Section 1311(i) of the ACA requires state Insurance Exchanges to fund a "Navigators" 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 played out 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.

This language does not preclude brokers or similar actors from participating in the Exchange as Navigators, provided that they receive no "direct" or "indirect" compensation from insurance

carriers for enrolling people in qualified health plans. HCFANY is supportive of the ACA's prohibition against conflicts of interests in enrollment for coverage.

Accordingly, the brokers may soon face a choice: either become Navigators and receive compensation through the grants provided by the Exchange or continue to sell products for dedicated carriers under their current commission structure. We believe this issue requires careful study and need not be resolved in order to pass appropriate Exchange legislation this session. A number of alternatives could be considered, such as brokers receiving commissions directly from the small group purchaser. The state would set a universal flat fee that consumers would pay directly to the broker when they purchase small group coverage either in the Exchange or outside the Exchange. This would eliminate any conflict of interest, allowing brokers to receive Navigator grants for helping individuals enroll in public or private coverage through the Exchange. It would also increase transparency for consumers. Small group purchasers in the Exchange who do not purchase through a broker would pay the same fee to the Exchange to cover administrative costs. Similarly, the issue of commissions for sale of individual plans would need careful consideration..

Navigators will help consumers with both public and private coverage, and will need different training and/or certification than that which both 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 who are seeking tax credits. (ACA § 1312(e)).

- ***What application and eligibility processes must be changed/streamlined for the state to comply with ACA requirements (attainment of subsidies, "no wrong door," portal requirements)?***

HCFANY firmly believes that New York should establish a "no wrong door" policy for its Exchange. Because so many New Yorkers are likely to migrate between public and private coverage, this means that public coverage and the subsidized commercial products must be as integrated as much as possible.

New York has taken important steps towards this transition. For example, we have streamlined eligibility systems by eliminating the asset test, 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," HCFANY urges the State to:

- 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;
- 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.

- ***Will both private and public insurance options be available within the Exchange? How will the Exchange account for adverse risk selection (i.e. large influx of high cost individuals into the Exchange)? Should insurers be required to offer the same coverage both inside the Exchange and outside the Exchange? How will New York effectively protect the Insurance market while creating a quality Exchange that has significant choice? Will the small group and individual markets be merged?***

HCFANY urges New York to establish a robust Insurance Exchange which integrates public and private coverage and pools risk inside and outside of the Exchange to the maximum extent possible. Section 1311(d)(4) of the ACA states that one of the functions of the Exchange shall be to inform individuals of the eligibility requirements and enroll them in Medicaid, CHP, or any other state or local public program. 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.

To best address the effects of possible adverse selection, HCFANY urges the merging of markets (as described above) to ensure the largest purchasing pool possible and to avoid isolation of high risk individuals in a few products. In addition, should New York elect to create a Basic Health Plan under Section 1331 of the ACA, the risk of these beneficiaries (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).

It seems unlikely that the bulk of the population who will be entering the Exchange will be significantly sicker than those currently enrolled in coverage. Recent projections indicate that this population might have significantly lower utilization rates for medical services, which may well offset any potential differential in morbidity. (E. Trish et al., "A Profile of Health Insurance Exchange Enrollees," Kaiser Family Foundation, March 2011).

To further remediate any potential adverse selection in the Exchange, insurers should be required to offer coverage outside the Exchange that is not lower in quality than the products being offered inside the Exchange. Most of the requirements set forth in the ACA already apply to both plans operating inside of the Exchange and those operating outside. However, Section 1311 includes additional requirements for all qualified health plans. This does not appear to extend to non-participating plans and could encourage plans outside of the Exchange to seek ways to attract better risk through marketing strategies or product modifications. (T. Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues," The Commonwealth Fund, September 2010). Any Exchange legislation put forth by New York should include language to hold plans operating outside of the Exchange to the same standards as those within the Exchange. However, the ACA's requirements for qualified health plans should be considered a floor, not a ceiling, for New York's health plans. Areas where New York currently exceeds the level of requirements in the ACA, such as in our mandated benefits, should be maintained in a uniform way inside and outside the Exchange.

Risk should 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 mechanism chosen should be administratively simple and designed to give

support to plans suffering adverse selection on the fastest schedule possible.

- ***Will the Exchange cater to business as well as individuals? Will employers be allowed to select group coverage for their employees throughout the Exchange?***

Section 1311(b) of the ACA requires states to establish a Small Business Health Options Program (SHOP), essentially an Insurance Exchange specifically for small employers seeking group coverage. While this SHOP Exchange can be separate from or combined with the main Exchange, HCFANY recommends that they be combined into one system. Both Exchanges would be accessed through different portals to give them the appearance of being separate. Keeping them together will allow the Sate to spread risk more effectively, maximize bargaining power, achieve greater administrative efficiency, and gather and use data in a uniform and more meaningful way.

- ***What steps should be taken in the near future to facilitate implementation?***

To best facilitate implementation of a New York Insurance Exchange, HCFANY recommends that the state adopt the most comprehensive Exchange statute as soon as possible. This should at the very least include the governance structure with strong consumer representation. To adequately control for conflicts of interests, HCFANY strongly urges that health insurers, brokers, providers, or any actor who has a financial interest in the policies debated by or decisions made by the governance board be prohibited from serving directly on the board.

Instead, New York should consider an alternative for these stakeholders similar to that pursued by Maryland in its state legislation (HB166) and allow them to instead serve on a stakeholder advisory committee to the board. This would allow them to offer guidance and expert advice to the board on a number of issues, but excuse them from any critical functions associated with Exchange oversight, management or any other decision-making that would affect their own financial interest or that of their company.

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