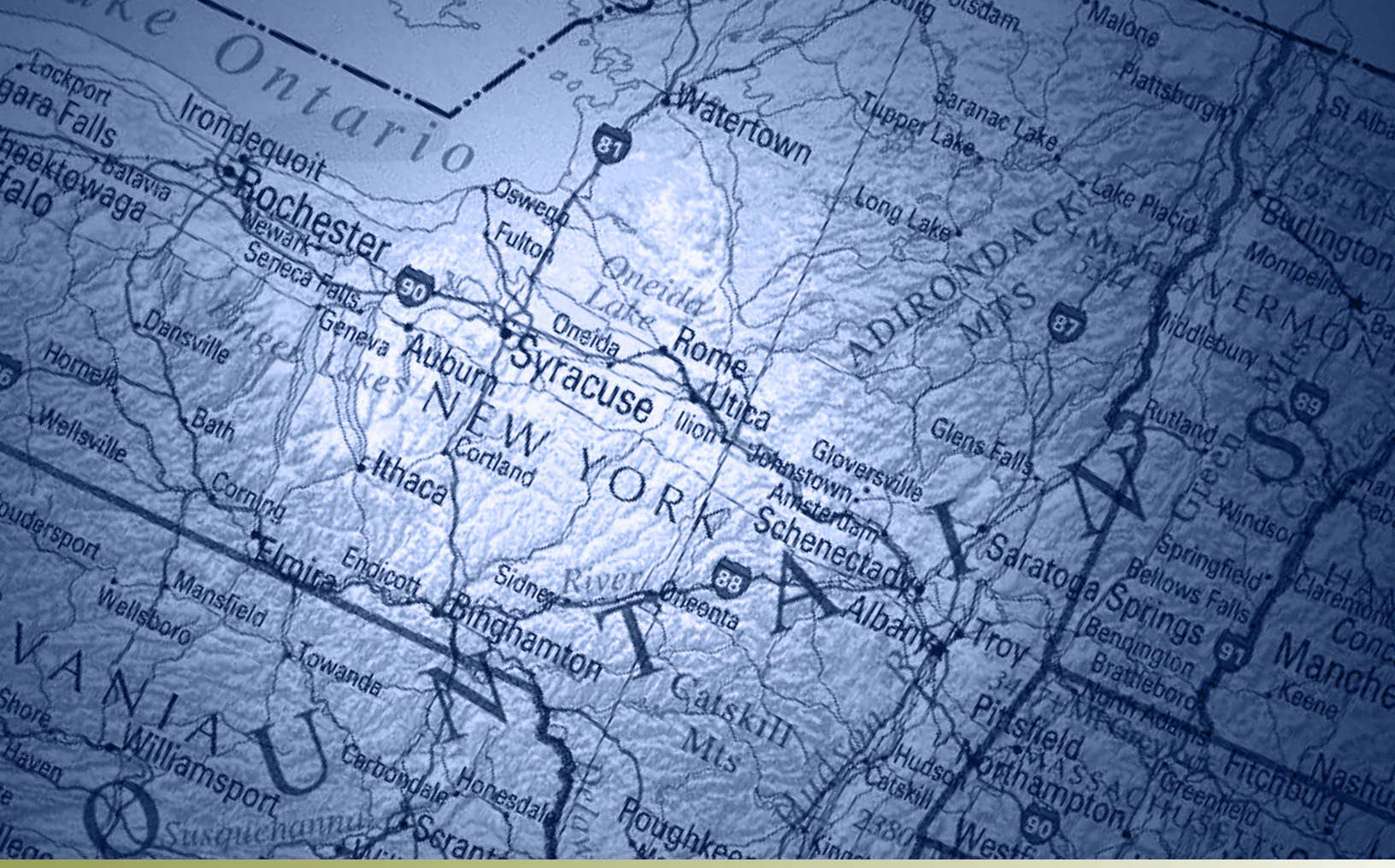

Implementing Federal Health Care Reform:

A Roadmap for New York State

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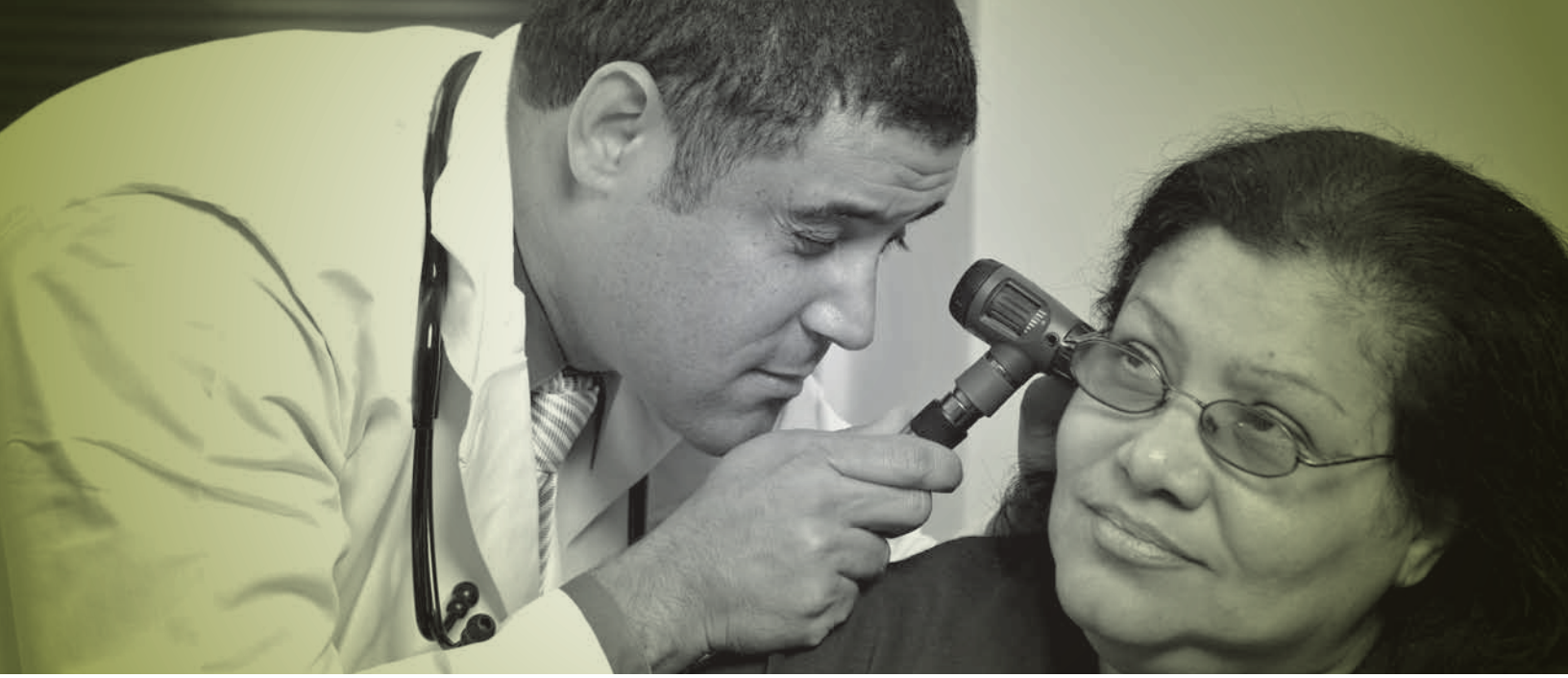

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Introduction

The Patient Protection and Affordable Care Act, and subsequent amendments under the Health Care Education and Reconciliation Act of 2010 (collectively referred to as the ACA), is sweeping Federal legislation designed to bring about near universal coverage, and transform how health care is provided and paid for throughout the United States. For New York, Federal health care reform brings significant new funding to the State's Medicaid program, creates a framework for expanding health insurance coverage and establishes new program authority and funding that will allow the State to drive significant delivery system reform. As a result of Federal health care reform, 2.23 million New Yorkers, or 85% of the total non-elderly uninsured in the State, will have access to health insurance; and more than 1 million uninsured New Yorkers are expected to obtain health coverage.[1]

While the ACA provides a national framework for reform, much of the responsibility for implementation falls to the states. As New York embarks upon health reform implementation, it starts with many strengths. New York is an "innovator state," one of a small group of states that has led the nation in terms of health care coverage. Over the past decade, New York has leveraged Federal funding to expand eligibility in its public insurance programs well beyond those populations mandated by Federal law. While the ACA requires state Medicaid programs to cover childless adults for the first time in 2014, New York has decades of experience providing coverage to this population. New York is home to one of the first and most robust Child Health Insurance Programs (CHIP, or Child Health Plus in New York) in the nation, and has dedicated significant resources to streamlining public health insurance eligibility systems and establishing outreach and enrollment assistance programs for public coverage. In the private insurance market, New York already has in place many of the ACA insurance reforms designed to protect consumers and enhance access to private insurance coverage. New York is a "guaranteed issue" state, thanks to State laws that require plans to sell coverage regardless of health status or demographics of the applicant. New York's community rating laws exceed even the new Federal standards, which prohibit discrimination in price based on anything other than family composition, geography, age, or tobacco use.

Yet New York faces significant challenges in implementing reform. The enormity and complexity of the Federal law is daunting for all states, and the need to reconcile New York's highly evolved regulatory and public coverage infrastructure with ACA mandates increases the complexity exponentially. Further, New York, like most states, is in the midst of a severe budgetary crisis that threatens to erode reimbursement rates for providers under existing public coverage programs, limit available resources for necessary infrastructure investments

[1] For the purposes of this paper, we rely on the take-up rates for the newly Medicaid eligible, and Medicaid eligible but uninsured populations developed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. Holahan, John and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Kaiser Commission on Medicaid and the Uninsured. May 2010. Available at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

including information systems, and shrink the very government agencies that will be charged with implementing reform. New leadership at the State's helm starting in January 2011 will have scarcely three years to design and implement changes necessary to meet Federal deadlines. And, these changes will be profound, requiring amendments to State statute, repeal of existing—and issuance of new—health and insurance regulations, the creation of new public and/or private governance entities, and the wholesale restructuring of longstanding statewide infrastructure and administrative systems.

Finally, the ACA includes a multitude of payment initiatives designed to improve the quality of care and slow health care cost growth. It is widely recognized that the way the nation pays for care encourages volume and not value. The ACA seeks to change this, making providers accountable for coordinating the care of their patients and rewarding better outcomes. Nowhere is this more important than in New York, where health care costs are among the highest in the nation and measures of health care quality too often lag. New York will want to ensure that the State and stakeholders secure Federal funding to support delivery system reengineering, including the expansion of the primary care workforce.

This report provides a health care reform implementation roadmap for New York State, summarizing the major provisions of the ACA, analyzing their implications unique to the State, and outlining the key implementation tasks and issues that New York will confront as it begins ACA implementation. ACA provisions are organized into three areas: **Coverage, Access for the Insured and Uninsured, and Payment and Delivery System Reform**. These three issue areas are inextricably linked, the success of health reform being dependent on their coordinated implementation. Coverage expansions, reforms, and mandates serve as cornerstones to reform, dramatically reducing the number of the uninsured, spreading the risk and costs of insurance across a greater and healthier pool of New Yorkers, and ensuring that health care providers have a reliable reimbursement mechanism to pay for their services. Access provisions, aimed at expanding the health care workforce and health care infrastructure, seek to ensure that health care providers are equipped to meet the rising demand for health services that is expected to accompany expanded coverage. Finally, reform of the State's delivery system is necessary to improve the quality and efficiency of health care delivery to ensure that coverage is affordable and sustainable for employers, consumers, and State and Federal governments alike. The specific changes described in this report for each area are summarized below.

Coverage: The ACA establishes a framework for expanding health insurance coverage. The report summarizes ACA provisions that: (i) expand New York's public health insurance programs; (ii) create a new health insurance exchange—a marketplace to connect consumers and employers to insurers; and (iii) make private health insurance more accessible.

Access for the Insured and the Uninsured: ACA changes in funding for primary care providers, the safety net delivery system, and the health care workforce are designed to enable states to ensure appropriate access to care for newly insured and those who remain uninsured by choice or because of eligibility or affordability constraints. The report outlines new reimbursement methodologies that invest in primary, community-based care, funding mechanisms designed to drive funding for uncompensated care to high-need safety net providers, and new funding streams to support health care work force development in the State.

Payment and Delivery System Reform: The report concludes with a discussion of the myriad payment and delivery system reform initiatives authorized and funded by the ACA. Specifically, this section highlights opportunities for New York to attract Federal funding that will support innovation in the State's health care delivery system.

For each major provision discussed in the report, a summary table outlines the main features of the provision, its effective date(s), the entities responsible for implementation, and the specific tasks and issues facing New York State as it moves forward with implementation.

New York's path to ACA implementation will be unique. Success will depend on the ability of State government leaders and their partners in the private sector to marshal the substantive expertise, political will, and human and financial resources necessary to capitalize on the opportunities presented by Federal reform to achieve transformative change. This report provides a starting point for that collaboration.

Coverage

The ACA makes sweeping changes that impact the availability, affordability, and funding of health insurance coverage in the United States, establishing a framework for near-universal coverage over the next decade. The reform law expands Medicaid and reconfigures eligibility standards under the program, mandates the creation of a health insurance exchange in each state through which individuals and businesses can purchase health insurance coverage, provides subsidies to eligible consumers to improve affordability of insurance coverage, and mandates a wide range of reforms to commercial insurance markets.

Today, there are 2.6 million uninsured children and non-elderly adults in the State. Of these, 1.1 million (42%) are currently eligible for Medicaid but uninsured, 1.1 million (42%) are not eligible for Medicaid due to their family incomes, and almost 400,000 (15%) are undocumented immigrants.

With the implementation of ACA public coverage and exchange provisions, a large majority of uninsured New Yorkers will be eligible for free or subsidized health insurance. Most of the 1.1 million New Yorkers who were eligible for Medicaid pre-ACA, but unenrolled, will remain eligible. An estimated 90,000 individuals will become newly eligible for Medicaid. Nearly 700,000 New Yorkers are estimated to become eligible to receive tax subsidies to purchase coverage through the exchange. An additional 340,000 uninsured people are estimated to become eligible to purchase coverage through the State exchange without Federal subsidies.[2]

The ACA provides historic and substantial opportunities to make affordable health insurance coverage a reality for New Yorkers. As many as 1.2 million New Yorkers are projected to become newly insured once ACA is fully phased in, based on estimated participation rates. Predictions of how many individuals will participate in the coverage options available to them vary. The Kaiser Commission on Medicaid and the Uninsured, for example, estimates take-up among those newly eligible for Medicaid and those Medicaid eligible but unenrolled using two scenarios: a "standard" scenario, assuming take-up of 57% among the newly eligible for Medicaid and 10% among those eligible for Medicaid but unenrolled, and an "enhanced" scenario assuming a 75% take-up among the newly eligible for Medicaid, and 40% among those eligible for Medicaid but unenrolled.[3]

Low and moderate income uninsured are expected to make up the vast majority of those newly gaining coverage under reform. Assuming the Kaiser enhanced take-up rate projections, as many as 440,000 individuals who were Medicaid eligible, but unenrolled prior to reform, will sign up. Among the 90,000 New Yorkers made newly eligible for Medicaid, up to 70,000 are projected to enroll. Among those moderate income uninsured who will be newly eligible for subsidies to purchase insurance through the new State exchange, approximately

[2] Insurance eligibility estimates based on original analysis by Manatt Health Solutions. See Table 1 and Appendix for methodology.

[3] Holahan, John and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Kaiser Commission on Medicaid and the Uninsured. May 2010. Available at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

Coverage *(continued)*

570,000 are expected to gain coverage. Finally, for the highest income group—those over 400% of the Federal poverty level who are not eligible for subsidies—an estimated 80,000 are also expected to purchase coverage and become newly insured.

While ACA is expected to dramatically expand health insurance coverage among New Yorkers, between 1.4 and 1.8 million New Yorkers could remain uninsured. If outreach and enrollment efforts fall short, many of the 1.1 million people who are currently eligible but not enrolled in Medicaid could still not enroll. Because ACA does not extend coverage to undocumented immigrants, an estimated 400,000 undocumented and uninsured immigrants may be left behind. In addition, 200,000 New Yorkers are expected to qualify for affordability waivers from the responsibility to purchase coverage; another 190,000 people may choose to pay a penalty rather than enroll in coverage.

Federal health reform presents a tremendous opportunity to dramatically shrink the State's uninsured population. Up to 1.2 million New Yorkers could gain coverage; a scale of expansion that is unprecedented. The ultimate impact of ACA on the number of uninsured in New York, however, will rest in large measure on how Federal health reform is implemented. Federal health reform opens up a world of new possibilities for New York State; turning its promise into reality rests on effective implementation by all stakeholders.

TABLE 1. How Will Federal Health Care Reform Affect Coverage in New York State?

	CURRENTLY UNINSURED	PERCENTAGE OF CURRENTLY UNINSURED	NEWLY INSURED POST-REFORM RANGE	REMAINING UNINSURED POST-REFORM RANGE
Eligible for Medicaid but Unenrolled	1,100,000	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 Ineligible for Medicaid or 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**

See Appendix for Table Methodology

PUBLIC COVERAGE PROVISIONS

Medicaid and the Children's Health Insurance Program (CHIP) serve as a foundation for enhancing health insurance coverage under Federal health reform. Most significantly, ACA establishes a new national minimum Medicaid financial eligibility level for many individuals under the age of 65, extends authority and funding for CHIP, and calls for streamlined eligibility and enrollment procedures for both Medicaid[4] and CHIP. Because New York is one of only five states that already offers coverage to childless adults and expanded coverage to parents under Medicaid, only a small subset of New Yorkers—roughly 90,000 childless adults between 100 and 133% of the Federal Poverty Level (FPL)—will become newly eligible for Medicaid as a result of the Federal expansion. However, enhanced Federal funding for those childless adults who are already eligible for Medicaid will bring significant new Federal resources to the State, and streamlined eligibility rules are likely to make it easier for eligible New Yorkers to get and keep their coverage.

Implications of ACA for New York's Partnership Plan

In 2009, New York submitted a waiver amendment to the Centers for Medicare & Medicaid Services (CMS) to implement State legislation:

- transitioning Medicaid income eligibility to a gross income test;
- increasing eligibility levels for pregnant women and infants to 230% of the Federal Poverty Level (FPL);
- aligning eligibility for children in Medicaid and their parents in Family Health Plus to 160% FPL; and
- increasing FHPlus eligibility levels for parents and childless adults to 200% FPL, pending CMS approval of 100% Federal funding for the expansion.

With the passage of health care reform, New York and CMS deferred discussion of the proposed FHPlus expansion pending guidance regarding Medicaid eligibility levels, the standard for calculating income, and the new Basic Health Program option. The Basic Health Program, as described below, is an alternative to enrollment in the health insurance exchange for non-Medicaid eligible individuals up to 200% FPL.

Medicaid Expansion (§ 2001[5])

Medicaid currently provides health coverage for more than 4.5 million New Yorkers.[6] New York Medicaid covers children under five up to 133% FPL, children aged six to 18 up to 100% FPL, pregnant women and infants up to 200% FPL, parents and young adults up to 83% FPL, and childless adults up to approximately 78% FPL. Elderly and disabled New Yorkers may in some cases receive coverage at slightly higher eligibility levels, as do children and adults participating in "waiver" programs, designed to meet their special health needs in a community-based, cost-effective manner. Finally, New Yorkers with incomes too high to qualify for traditional Medicaid

[4] Kaiser Commission on Medicaid and the Uninsured. "Where are the States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults." December 2009. Available at: http://tinyurl.com/23pfobw.

[5] All citations are to sections of the Affordable Care Act (ACA), unless otherwise noted.

[6] New York State Department of Health. Number of Medicaid Beneficiaries by Category of Eligibility and Social Service District. September 2009. Available at: http://www.health.state.ny.us/nysdoh/medstat/el2009/2009-09_enrollees.xls.

may be eligible to participate in Family Health Plus (FHPlus), a Medicaid-funded program that provides a somewhat more limited benefit package to parents and young adults (ages 19–20) with incomes up to 150% FPL and childless adults with incomes up to 100% FPL. Children with incomes above Medicaid thresholds are eligible for CHPlus, New York's CHIP program that offers coverage on a sliding scale basis with subsidies up to 400% FPL.

TABLE 2. Current New York State Income Eligibility Levels[7]

ELIGIBILITY GROUP	CURRENT MEDICAID INCOME LEVELS (NET INCOME STANDARD)	CURRENT FHPLUS CHPLUS INCOME LEVELS (GROSS INCOME STANDARD)
Parents	Approx. 83% FPL	150% FPL
Pregnant Women	100% FPL *(full coverage)*	
	200% FPL *(prenatal and maternity coverage)*	
Childless Adults	Approx. 78% FPL	100% FPL
19 and 20 year olds	Approx. 83% FPL	150% FPL
Children < 1	200% FPL	No limit; subsidies < 400% FPL
Children, ages 1–5	133% FPL	No limit; subsidies < 400% FPL
Children, ages 6–18	100% FPL	No limit; subsidies < 400% FPL

Once fully implemented, the Federal Medicaid expansion is likely to result in a significant increase in the number of New Yorkers receiving Medicaid. As many as 70,000 new Medicaid enrollees will come into the program as a result of the increase in the eligibility level for childless adults from 100% to 133% FPL; a reduction in churning on and off of Medicaid will increase enrollment among currently eligible but uninsured individuals by as much as 440,000 enrollees—referred to as the "woodwork" or "welcome mat" effect.

Coverage for Individuals with Income at or Below 133% of the Federal Poverty Level (§ 2001(a)). Effective 2014, Federal health care reform establishes a new national Medicaid eligibility threshold for most individuals under age 65, providing coverage for those who have income levels up to 133% FPL.[8] In New York, these minimum income eligibility levels will result in new Medicaid eligibility for approximately 90,000 New Yorkers who are childless adults between 100% and 133% FPL. In addition, for children aged six to 18 and parents with incomes between 100% and 133% FPL, this change appears to require a shift in eligibility from CHPlus to Medicaid and from FHPlus to Medicaid, respectively.

New York will have to determine how the State will meet coverage needs for populations currently covered under its Medicaid waiver, The Partnership Plan, at income levels that exceed the new Federal Medicaid standard, including pregnant women up to 200% FPL and parents and young adults up to 150% FPL. The ACA allows New York to continue providing coverage for individuals over 133% FPL and receive its standard Federal Medical Assistance Percentage

[7] In the 2009-2010 state budget, the Legislature enacted statute to change Medicaid eligibility to a gross income standard, increase Medicaid eligibility to 230% FPL for infants and pregnant women, and increase FHPlus eligibility to 160% FPL for parents, thus aligning coverage and eligibility determination rules for parents their children. New York never implemented these changes (see call out box on page 2 regarding New York's Partnership Plan.) This table reflects eligibility levels and standards that are currently operational in New York.

[8] Effective 2014, ACA also requires states to provide coverage to current and former foster children up to age 26.

(FMAP or the Federal share of a state's Medicaid costs). New York's standard FMAP rate is 50%. Specifically, the law creates a new optional Medicaid eligibility group that would allow coverage of non-elderly individuals with incomes above 133% FPL starting in 2014, provided that higher income individuals cannot be covered before lower income individuals nor parents enroll in Medicaid coverage while their children remain uninsured. The ACA makes further conforming amendments that have the effect of providing Federal funding at the standard FMAP level for coverage of this population.[9] The State's additional options for covering these populations in 2014 include: (i) transitioning them to the exchange, and (ii) creating a Basic Health Program for these and other consumers with incomes from 133–200% FPL (see Section C, below, for a discussion of the Basic Health Program).

Medicaid Benchmark Benefits Must Consist of At Least Minimum Essential Coverage (§ 2001 (c)). Under the ACA, New York must provide the newly expanded population, including childless adults, parents and children in the expansion group, with a "benchmark" benefit package consistent with the Federal definition of benchmark in statute.[10] The law states that benchmark benefits may be less generous than the benefits available for individuals currently eligible for Medicaid coverage, but must be at least as generous as the narrower "essential health benefits" offered by private health insurance plans in the new State Health Insurance Exchange (hereinafter, "the exchange") to be established under ACA by 2014 (discussed on page 20 of this report). Significantly, the definition of benchmark includes four options, including an option for "Secretary-approved coverage."[11] Thus, it may be possible for New York to secure Department of Health and Human Services (HHS) approval for a benchmark package that is consistent with benefits New York now provides under FHPlus or Medicaid. The law also requires that mental health services, prescription drugs and family planning services and supplies be included as part of the benchmark benefit.[12] A comparison of essential benefits with current Medicaid, FHPlus, and CHPlus benefits is provided in the following table.

The ACA also provides for a higher FMAP for certain expansion populations in New York. However, FMAP enhancements will only apply for beneficiaries receiving the benchmark benefit package approved by the Secretary. For children with incomes from 100–133% FPL who become newly Medicaid eligible in 2014, New York must ensure access to the full range of Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT) benefits guaranteed under Medicaid, which may require the wraparound benefits to supplement the benchmark package for children.[13]

[9] §2001(e)(2)(A) and (B).

[10] Benchmark benefits are defined in Federal Medicaid law as being benefits comparable to those offered through insurance provided to state or Federal employees, insurance provided by the largest private HMO in the State, the actuarial equivalent of these options, or a plan approved by Federal Medicaid officials. Social Security Act ((SSA) Sec. 1937. [42 U.S.C. 1396u-7]).

[11] Social Security Act § 1937(b)(1)(D) [42 U.S.C. 1396u-7(b)(1)(D)].

[12] §§2001(c), 2303(c).

[13] ACA requires that the entire expansion population, including children, receive benchmark benefits. However, the Social Security Act specifies that children receiving benchmark benefits are still entitled to the full range of Medicaid benefits guaranteed to children under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). See Social Security Act § 1937 [42 U.S.C. § 1396u-7] and State Medicaid Director's Letter #06806810-005, "§ 6044 of the Deficit Reduction Act of 2005," March 31, 2006, and State Medicaid Director's Letter #10-005, "New Option for Covering Individuals Under Medicaid," April 9, 2010.

TABLE 3. Comparison of Benefits

BENEFITS	BENCHMARK/ ESSENTIAL BENEFITS PACKAGE	NEW YORK MEDICAID	FAMILY HEALTH PLUS	CHILD HEALTH PLUS
Ambulatory Care	✓	✓	✓	✓
Emergency Services	✓	✓	✓	✓
Family Planning	✓	✓	✓	✓
Hospitalization	✓	✓	✓	✓
Maternity and Newborn Care	✓	✓	Only Maternity Care	✓
Mental Health and Substance Abuse Services	✓	✓	✓	✓
Prescription Drugs	✓	✓	✓	✓
Rehabilitative/Habilitative Services & Devices	✓	✓	✓	✓
Laboratory Services	✓	✓	✓	✓
Preventive and Wellness Services, including Chronic Disease Management	✓	✓	✓	✓
Pediatric Services, including Oral/Vision Care	✓	✓		✓
Family Planning Services and Supplies	✓	✓	✓	✓
Elective Abortion		✓*	✓*	✓*
Dental Services		✓	Some plans	✓
Vision Services		✓	✓	✓
Long-Term Care		✓		Limited coverage
Medical Case Management		✓		
Podiatry Services		Children <21 and persons with certain diagnoses	Persons who are 19 or 20 years of age	✓
Audiology and Hearing Aids		✓	✓	✓
Durable Medical Equipment		✓	✓	✓
Emergency Medical Transportation		✓	✓	✓
Orthotics and Prosthetics		✓	✓	✓
Home Health Care		✓	✓	✓

*State only dollars

Sources: Patient Protection and Affordable Care Act P.L. 111-48 and Modifications by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); New York State Medicaid Managed Care Model Member Handbook; New York State Family Health Plus Model Member Handbook; New York State CHIP Model Contract.

(See further discussion of "essential health benefits" on page 23, State Health Insurance Exchanges.)

Federal Funding for Cost of Covering Newly Eligible Individuals (§ 2001(a)(3)). Under ACA, New York will receive enhanced Federal funding for childless adults in Medicaid. The law provides for different FMAP enhancement methodologies for states that will be newly covering childless adults and parents between state welfare levels and 133% FPL, and "Expansion States," like New York, that have already extended coverage to parents and childless adults above 100% FPL. Specifically, ACA creates an Expansion State FMAP formula which begins in 2014 and gradually reduces New York's state share of Medicaid costs for non-pregnant, childless adults under age 65 up to 100% FPL; enhanced Federal funding begins in 2014 and reaches 90% in 2020 and beyond. Significantly, this FMAP enhancement reduces New York's obligation to fund 50% of Medicaid costs for 940,000 childless adults[14] currently in the Medicaid and FHPlus programs and any new beneficiaries with incomes under 100% FPL who come into the program. Ultimately, New York will be responsible for just 10% of the Medicaid of this population.

For non-pregnant childless adults in New York with incomes from 100% to 133% FPL who will become newly eligible for Medicaid in 2014, New York will receive a separate, enhanced FMAP rate starting at 100% in 2014 and going down to 90% in 2020 and beyond. New York will continue to receive a 50% FMAP for children, parents and beneficiaries who are disabled or over 65.[15]

TABLE 4. FMAP for Currently Eligible and Newly Eligible Childless Adults

YEAR	EXPANSION FMAP FOR ADULTS ALREADY ELIGIBLE UNDER NY MEDICAID		ENHANCEMENT FMAP FOR NEWLY ELIGIBLE ADULTS UNDER ACA	
	CHILDLESS ADULTS UP TO 100% FPL		CHILDLESS ADULTS FROM 100%–133% FPL	
	State Share	Federal Share	State Share	Federal Share
2014	25%	75%	0%	100%
2015	20%	80%	0%	100%
2016	15%	85%	0%	100%
2017	10%	90%	5%	95%
2018	5%	95%	6%	94%
2019	7%	93%	7%	93%
2020+	10%	90%	10%	90%

Source: Manatt Health Solutions analysis of the ACA.

New York has the option to expand eligibility prior to 2014, but will receive its existing base match rate of 50% until 2014.[16]

[14] Data compiled by New York State Department of Health. June 2010.

[15] The American Recovery and Reinvestment Act of 2009 (Public Law 111-5), also known as the Federal stimulus package, enhanced New York's FMAP to approximately 62% through December 31, 2010.

[16] The increased FMAP that New York has been receiving under the American Recovery and Reinvestment Act of 2009 would not be available if the State elects to implement the Medicaid expansion before 2014. State Medicaid Director's Letter (SMDL) #10-005 "New Option for Covering Individuals Under Medicaid," April 9, 2010.

ACA Medicaid Drug Rebate Program (MDRP) Provisions

The MDRP was created by the Federal Omnibus Budget Reconciliation Act of 1990 ("OBRA '90")[17] to ensure that states receive prescription drug discounts similar to those manufacturers provide private purchasers.[18, 19] Effective January 1, 2010, ACA increases the Medicaid rebate under the MDRP: (i) for most brand drugs from minimum of 15.1% to 23.1% of Average Manufacturer Price (AMP); and (ii) for generic drugs from 11% to 13% of AMP. Unlike current Medicaid rebates, the incremental savings associated with the increase to the minimum rebate percentage will flow solely to the Federal government and will not be shared with the states.[20] New York State has historically maximized supplemental rebate agreements with manufacturers, which the State has shared with the Federal government. It is unclear how the increase to the minimum rebate percentage in ACA will affect the State's supplemental rebate agreements. Specifically, it is unclear whether the new minimum will come close to or exceed current supplements, and whether manufacturers will agree to new supplemental rebate agreements over the new minimum rebate price point. If the new minimum has the effect of reducing or eliminating New York's supplemental rebate arrangements, the State stands to lose an estimated $100 million annually that currently flows to its Medicaid program.[21] New York also has significant implementation tasks related to the new drug rebate provisions in ACA including, at a minimum, major system modifications to ensure accurate rebate invoicing and reconciliation.

Federal Funding Opportunities for New York State. The ACA provides several small and large opportunities for the State to substitute Federal Medicaid dollars for State dollars and thereby produce State savings. As noted above, under the ACA, New York will receive a higher FMAP for the cost of covering childless adults. Today, New York provides Medicaid coverage at a 50% Federal matching rate to almost 1 million childless adults with incomes below 100% FPL. From 2014 to 2020, the Federal matching rate for these beneficiaries will increase from 75% to 90%, and New York will be able to save a commensurate amount in State spending. New York will save additional monies in 2015 when the Federal matching rate for CHPlus is increased by 23 percentage points—from 65% to 88% (see discussion of ACA CHIP provisions on page 17). In addition, the State may secure additional enhanced FMAP by adopting certain changes to its Medicaid program including adopting health homes, expanding community-based long-term care, and providing certain preventive care services.

[17] Pub. L. No. 101-508, § 4401, 104 Stat. 1388, 1388–143-161 (codified at 42 U.S.C. § 1396r-8 (2000)).

[18] State Medicaid programs do not purchase drugs directly; they reimburse pharmacies for covered drugs dispensed to Medicaid beneficiaries. Each state defines its pharmacy reimbursement formulas, which include the drug ingredient cost plus a dispensing fee.

[19] The Medicaid Drug Rebate Program was amended by the Veterans Health Care Act of 1992 ("VHCA"). Under VHCA, drug manufacturers are required to enter a pricing agreement with HHS for the § 340B Drug Pricing Program, which is administered by the Health Resources and Services Administration. In addition, VHCA requires drug manufacturers to enter into various pricing agreements with the Department of Veterans Affairs.

[20] Public Laws 111-148&111-152: § 2501. See also Cindy Mann, Director, Center for Medicaid, CHIP, and Survey & Certification. State Medicaid Director Letter #10-0006. April 22, 2010.

[21] New York State Department of Health estimate prepared by its pharmacy benefit manager, Magellan Medicaid Services.

After 2014, New York will also have the opportunity to reduce or eliminate support for current insurance options that may not be needed after implementation of Federal reform. For example, the State may create a Basic Health Program to cover pregnant women, parents and eventually children with incomes over the new 133% FPL threshold, up to 200% FPL. New York may likewise revisit State subsidies for Healthy New York, as well as the individual market.

The foregoing discussion highlights areas where New York may decrease State spending under the ACA. These savings will be offset to some degree by the administrative costs required to implement Federal reform, and the cost of covering a large influx of new Medicaid enrollees from the 90,000 childless adults with incomes between 100% and 133% FPL eligible for Medicaid for the first time, as well as from among the 1.1 million who are eligible for Medicaid but not enrolled.

STATE IMPLEMENTATION: CHART 1. Medicaid Expansion	
SUMMARY	ACA sets a new, national Medicaid threshold at 133% FPL. Newly eligible enrollees will receive a "benchmark" benefit package that must be approved by CMS and include at least the essential benefits required in the exchange. The benchmark benefit may be less generous than Medicaid. The law will provide new coverage in New York for childless adults between 100–133% FPL.
EFFECTIVE DATES	January 1, 2014
FEDERAL FUNDING	New York will receive enhanced Federal funding for childless adults in Medicaid. For childless adults up to 100% FPL, ACA reduces New York's state share gradually beginning in 2014. For newly eligible adults (100–133 FPL), the State will receive an enhanced FMAP rate of 100% in 2014 that gradually declines. The two rates merge over time; New York will receive a 90% FMAP for its entire childless adult populations in 2020 and beyond.
RESPONSIBLE PARTIES	▸ CMS will issue guidance with respect to the expansion in Medicaid. ▸ New York State Department of Health will be responsible for implementing the expansion. ▸ New York's Legislature will enact conforming legislation aligning New York's Medicaid eligibility levels with new Federal parameters.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks** ▸ Amend State Plan and/or Waiver as needed. ▸ Implement changes to the application and enrollment processes for Medicaid and CHPlus. ▸ Implement eligibility systems changes necessary to effectuate the expansion, including programming new eligibility categories that enable New York to accurately claim enhanced FMAP for childless adults. ▸ Implement the eligibility systems design or changes necessary to achieve connectivity with the State exchange. ▸ Obtain CMS approval for a benchmark benefit package. ▸ Seek changes to State law related to Medicaid, CHPlus, and FHPlus eligibility levels as required by ACA. ▸ Transition certain children in CHPlus and adults in FHPlus to Medicaid in 2014.

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STATE IMPLEMENTATION: CHART 1. Medicaid Expansion	
STATE IMPLEMENTATION TASKS/ISSUES (CONTINUED)	**Issues**
	▸ How will parents and young adults with incomes between 133% FPL and 150% FPL who are currently covered in Family Health Plus secure coverage? Will the State maintain the FHPlus program for these individuals? Will it create a Basic Health Program?
	▸ How will documented and undocumented pregnant women with incomes between 133% and 200% FPL who are currently covered in Medicaid secure coverage? Will New York maintain these pregnant women in the Medicaid program? Will these women be transitioned into a Basic Health Program or the exchange? What are the implications of pregnant women enrolling in the exchange for the State's ability to enroll eligible newborns in Medicaid?
	▸ What will New York's benchmark package be? Current Medicaid benefit? FHPlus? Other?
	▸ Will long-term care be part of the benchmark package? If not, what are the implications of the benchmark for disabled Medicaid beneficiaries above current standard Medicaid income eligibility levels?

Changes in Medicaid Eligibility and Enrollment Rules

In 2014, Federal reform requires states to change their Medicaid and CHIP eligibility rules in three fundamental ways for the majority of enrollees: **1)** states must change the way income is counted for the purposes of determining eligibility; **2)** states must eliminate the asset test for target populations; and **3)** states must make a series of changes intended to improve the process for determining and maintaining eligibility within their public programs.

Income Counting Rules Replaced by Modified Adjusted Gross Income (§ 2002). ACA requires New York to change the way it calculates income for the purposes of determining Medicaid and CHPlus eligibility for the majority of enrollees with the goal of creating a single set of eligibility rules that will apply nationally to Medicaid, CHIP, and the exchange. Today, Medicaid and CHIP allow applicants to deduct certain childcare expenses, child support payments, the first $90 of earned income and other deductions at the State's discretion before determining eligibility.[22] In addition, certain other income is not "counted" or is "disregarded" in Medicaid. While these income rules have the effect of increasing eligibility standards for many families, they also make the application process more complex. Federal reform simplifies such income-counting rules by aligning them with a single Federal standard articulated in Federal tax law called the "modified adjusted gross income" ("MAGI").[23] In order to help offset the impact of the changes in these income rules, the new methodology modifies the adjusted gross income by allowing an across the board 5% income disregard for all applicants. Thus, the expanded eligibility under Medicaid, in effect, is automatically increased from 133% FPL to 138% FPL. Income will not be calculated on a MAGI basis for all individuals. Individuals who are elderly, disabled, medically needy, or deemed eligible for Medicaid as a result of other programs will not be subject to the MAGI eligibility standard.

Elimination of the Asset Test (§ 2002). The ACA also requires that, beginning in 2014, states eliminate Medicaid asset tests for the same adults impacted by MAGI. Because neither the exchange nor CHIP has an asset test, this ensures alignment across programs. Similar to the application of MAGI, this change does not apply to Medicaid recipients who are elderly,

[22] SSA Sec. 1931.

[23] Internal Revenue Code of 1986 § 36B(d)(2), as amended by ACA § 1401 and HCERA § 1004(a)(2).

disabled, medically needy, or deemed eligible for Medicaid as a result of other programs such as Temporary Assistance for Needy Families (TANF). New York does not currently have an asset test for the MAGI populations; however, it has in the past, and reinstatement of the asset test has been the subject of recent proposals by members of the Legislature. Under ACA, such proposals could not become law without risking New York's Federal Medicaid and CHPlus funding.

Enrollment Simplification (§§ 1413, 2201). ACA includes additional provisions aimed at simplying eligibility and enrollment procedures for Medicaid and CHIP for the non-elderly and disabled, and ensuring coordination with coverage available through newly created state exchanges. Ultimately, the enrollment processes for individuals eligible for subsidies, whether under Medicaid, CHPlus or through the exchange, must be seamless. By January 1, 2014, New York must implement a series of procedures that provide for simplified enrollment in Medicaid and CHPlus and coordination with the exchange, or risk losing Federal funding for these programs. Required enrollment simplification and coordination procedures include:

- utilizing a single, streamlined application form for Medicaid, CHPlus, and subsidies for coverage through the exchange or other State programs;
- establishing a website that permits individuals to apply to, enroll in, and renew enrollment in Medicaid, and consent to enrollment or re-enrollment in such coverage through electronic signature.

Enrollment Technology Standards and Protocols (§ 1561)

By September 23, 2010, in consultation with the Federal HIT Policy Committee and the HIT Standards Committee, HHS must develop interoperable and secure standards and protocols that facilitate enrollment and renewal in Federal and state programs. These standards and protocols must allow for:

- Electronic matching against existing Federal and state data.
- Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.
- Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.
- Capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations.
- Ability to expand the enrollment system to integrate new programs, rules, and functionalities to operate at increased volume.
- Notification of eligibility, recertification, and other communications about eligibility via e-mail and cell phone.
- Other functionalities necessary to provide eligibles with streamlined enrollment process.

Funding is available to state and local governments for the development and adaptation of systems to these new standards and protocols. ACA specifies that state and local governments must submit applications outlining a plan to adopt and implement appropriate enrollment technology to secure funding, but does not provide further details on the application process, funding levels, any matching requirements, or timing. Presumably this information will accompany further Federal guidance and a funding announcement related to the provision.

The law also requires states to establish procedures for conducting outreach to and enrolling vulnerable populations including children, homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance abuse-related disorders, and individuals with HIV/AIDS.[24]

Conforming changes are required at the Federal level. HHS must establish a system to coordinate enrollment and eligibility determination and re-determination for participation in state health subsidy programs and ensure that Medicaid- or CHPlus-eligible individuals who apply for coverage through the exchange are enrolled in the applicable public insurance program. Further Federal guidance, including a model, simplified and streamlined enrollment form, will significantly inform the implementation of these provisions.

The cost to New York State of administering the changes to the Medicaid and CHPlus systems is likely to be significant. The State will need to develop and upgrade eligibility systems infrastructure, which is currently embedded in New York's legacy Welfare Management System or WMS. WMS was developed in the 1970s and still resides under the auspices of New York's public assistance agency, the Office of Temporary and Disability Assistance (OTDA). Upgrading or replacing this system will be costly and complicated. New York is also in the process of implementation planning for a new Enrollment Center, authorized by the State Legislature in 2008 to enhance public health insurance eligibility and enrollment capacity through telephone renewal, centralized consumer support, and Web-based application and renewal. The State will likely re-evaluate its plan for the Enrollment Center in light of new eligibility simplification and exchange alignment requirements in ACA.

While some funding is available through traditional Federal Medicaid support for administration, state matching funds will be required to draw down funding. In addition, ACA makes Federal grants available to states to implement state-based exchanges, though neither the appropriation amounts nor the grant application process is articulated in ACA.

STATE IMPLEMENTATION: CHART 2. Changes in Medicaid Eligibility Rules

SUMMARY	ACA mandates (i) use of a new, simpler formula—Modified Adjusted Gross Income—to calculate income eligibility in Medicaid and CHIP for non-elderly and non-disabled; and (ii) simplification of enrollment procedures in New York's public health insurance programs.
EFFECTIVE DATES	January 1, 2014
RESPONSIBLE PARTIES	▸ CMS will issue guidance regarding MAGI and enrollment simplification and alignment.
	▸ The HHS Office of the National Coordinator for Health IT (ONC) will promulgate enrollment technology standards for public insurance programs.
	▸ The New York State Department of Health will implement MAGI, and conform enrollment and eligibility systems and processes to meet ACA requirements.
	▸ The New York State Legislature will enact statute to change eligibility and enrollment in Medicaid and CHPlus consistent with ACA requirements.

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[24] Public Laws 111-148&111-152: § 2201.

STATE IMPLEMENTATION: CHART 2. Changes in Medicaid Eligibility Rules

(CONTINUED) STATE IMPLEMENTATION TASKS/ISSUES	
Tasks	
	Work with CMS to develop guidance with respect to MAGI, and align new requirements and existing Medicaid rules.
	Identify existing eligibility categories impacted by MAGI.
	Submit to HHS the procedures that will be used to calculate income and income eligibility for Medicaid and CHPlus under MAGI.
	Ensure that children do not lose coverage as a result of the transition to MAGI.
	Develop new standard application for enrollment in public health insurance programs and the exchange.
	Develop website through which consumers can enroll and renew health insurance coverage in public insurance programs and the exchange.
	Develop and upgrade systems infrastructure to implement MAGI, integrate Medicaid and CHPlus eligibility and enrollment with the exchange, and effectuate data matching with Federal systems.
Issues	
	How will New York manage and fund systems changes that will require significant human and financial resources to implement?
	How will New York coordinate the enrollment and eligibility rules, procedures, and systems for MAGI and Non-MAGI (Aged, Blind and Disabled) populations? Does ACA effectively create two separate Medicaid programs in New York?
	How will Medicaid's "point in time" and "countable income" requirements mesh with the new MAGI standard?
	Does New York's planned Enrollment Center play a role in public program eligibility determinations and their coordination with the exchange?
	What role will counties play in eligibility and enrollment?
	Will some individuals lose coverage under MAGI and, if so, how will they be transitioned to the exchange or other coverage?
	How will other state subsidized programs be integrated into eligibility and enrollment simplification planning (EPIC, ADAP, COBRA, FHPlus EBI, premium assistance, etc.)?

Maintenance of Effort (§ 2001(gg) and § 2101(b)

The ACA imposes a maintenance of effort (MOE) requirement prohibiting states from imposing eligibility rules and enrollment methodologies or procedures in their state Medicaid and CHIP programs that are more restrictive than the eligibility and enrollment requirements in place on March 23, 2010, the date ACA was signed into law. The MOE requirement continues for adults until 2014, when HHS certifies that the state exchange is fully operational and states are bound only by the new Medicaid threshold. For children covered by Medicaid and CHPlus, the MOE continues until October 1, 2019, after which time states may transition children to the exchange, but only upon a finding by the Secretary that comparable pediatric coverage is provided by

participating qualified health plans. New York would risk Federal support for both the Medicaid and CHPlus programs for any violations of MOE. ACA does not appear to prohibit states from seeking savings by reducing provider payments or restricting optional benefits in Medicaid.

STATE IMPLEMENTATION: CHART 3. Maintenance of Effort	
SUMMARY	The State must maintain eligibility rules in Medicaid and CHPlus that are no more restrictive than rules in place on March 23, 2010.
EFFECTIVE DATES	For Adults: March 23, 2010 through the HHS certification of a fully operational state exchange. For Children: March 23, 2010 through October 1, 2019.
RESPONSIBLE PARTIES	▸ CMS is expected to issue MOE guidance in the next several months.
	▸ The New York State Department of Health will monitor and ensure compliance with MOE.
STATE IMPLEMENTATION TASKS/ISSUES	Tasks
	▸ Monitor and comply with MOE to ensure that New York receives full Federal funding for its Medicaid and CHPlus programs.

Changes to the Children's Health Insurance Program (CHIP) (§§ 2101, 2102, 10203(c), 10203(d), HCERA[25] § 1004(b)(2))

CHPlus provides coverage for 390,000 children with family incomes above Medicaid eligibility levels.[26] New York uses Federal CHIP and State funding to fully fund coverage for children with family incomes up to 160% FPL, and to subsidize coverage for children with family incomes between 160% and 400% FPL. The State receives a Federal matching rate of 65% for its CHPlus program expenses.

Families with incomes over 400% FPL can "buy-in" to CHPlus by paying the full premium (on average, $175 per child per month). CHPlus covers any child who is a resident of New York State regardless of citizenship or immigration status.

TABLE 5. New York State CHPlus—Premium Subsidies

INCOME LEVEL	PER CHILD PREMIUM	FAMILY PREMIUM CAP
<160% FPL	$0	$0
160–222% FPL	$9	$27
223–250% FPL	$15	$45
251–300% FPL	$30	$90
301–350% FPL	$45	$135
351–400% FPL	$60	$180

[25] Health Care Education and Reconciliation Act.

[26] New York State Department of Health. Child Health Plus Enrollment by Insurer. April 2010. Available at: http://www.health.state.ny.us/statistics/child_health_plus/enrollment/.

Federal health care reform effectuates new eligibility parameters for CHPlus, reauthorizes Federal CHIP funding, enhances the State's FMAP for the program, and imposes a CHPlus maintenance of effort (MOE) requirement. In short, ACA funds CHPlus through 2015 and requires New York to maintain its current CHPlus program, except that in 2014, children with incomes between 100% and 133% FPL will transition to Medicaid and receive the benchmark benefit plus full EPSDT services. After 2015, New York's matching rate will increase to 88% and New York will be subject to the MOE requirement until 2019. Congressional action will be required to continue CHIP funding beyond 2015, when new Federal funds are no longer available. The CHPlus MOE requirement ends in 2019 and CHPlus children will transition into the exchange or into a Basic Health Program (if New York determines to establish one).

TABLE 6. Current Eligibility Levels for CHPlus

NEW YORK STATE CHPLUS PROGRAM	CURRENT ELIGIBILITY LEVELS
Children < age 1	> 200% FPL
Children age 1–5	> 133% FPL
Children age 6–18	> 100% FPL

Transition of Children from CHPlus to Medicaid (§ 2001[a]). With the implementation of the new Federal Medicaid eligibility threshold in 2014, roughly 89,000 children with family incomes from 100%–133% FPL who are currently covered by CHPlus will become eligible for the State's Medicaid program.[27] The law appears to require New York to transition these children to the Medicaid program.[28]

Federal Funding for CHPlus (§§ 2101[a], 10203). ACA extends Federal CHIP funding through September 30, 2015. After 2015, the future of the CHPlus program is uncertain; while states will be operating under a mandate to maintain CHPlus eligibility levels through 2019, this mandate is unfunded by the Federal government after 2015. In the event that states exhaust available Federal CHIP funds, the law requires that children enrolled in CHIP be transitioned to Medicaid coverage, if eligible, or into exchange coverage. The law also enhances the CHIP FMAP beginning October 1, 2015 through September 30, 2019 by increasing the Federal share of CHPlus expenses by 23 percentage points, from a 65% to an 88% match in New York. ACA requires that in the event of Federal funding shortfalls at any point between 2014 and 2019, the State have procedures in place to transition CHPlus eligible children to alternate sources of coverage—either Medicaid or the exchange. Specifically, New York would be required to have children's coverage available through a qualified plan in the exchange that is comparable to CHPlus in terms of both benefits and cost-sharing requirements. The HHS Secretary would have to certify that children's coverage comparability through the exchange.

[27] Data estimate provided by the New York State Department of Health.

[28] Section 2001(a)(1) and 2001(a)(4) (creating new Social Security Act Section 1902(k)(3)).

STATE IMPLEMENTATION: CHART 4. Enhanced Federal Support for CHIP	
SUMMARY	ACA effectuates new eligibility parameters in CHPlus related to the Medicaid expansion, authorizes two additional years of CHIP funding, enhances FMAP for the CHPlus program, and establishes an MOE requirement that the State has to meet to keep its Federal Medicaid and CHIP funding.
EFFECTIVE DATE(S)	▸ March 23, 2010 through September 30, 2019: CHIP MOE.
	▸ September 30, 2015: Federal CHIP funding authorization end date.
	▸ October 1, 2015: Federal matching for CHPlus is enhanced to 88%.
	▸ October 1, 2015: State permitted to enroll CHPlus children who are citizens or legal immigrants in comparable coverage through the exchange.
	▸ By April 1, 2015: Secretary shall review and certify exchange coverage for children to ensure that benefits and cost-sharing are comparable to State CHIP benefits.
RESPONSIBLE PARTIES	▸ CMS will issue guidance on the CHIP MOE requirement.
	▸ Congress will determine CHIP funding reauthorization beyond 2015.
	▸ The New York State Department of Health will be responsible for meeting MOE, effectuating coverage transitions, and ensuring (if necessary) that CHPlus comparable coverage is available through the exchange until 2019.
	▸ The Legislature will enact statute to change CHPlus eligibility levels consistent with the new Medicaid threshold and to effectuate other changes to CHPlus consistent with ACA implementation.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Meet MOE requirement.
	▸ Transition children at 100–133% FPL from CHPlus to Medicaid.
	Issues
	▸ With a functioning exchange in 2014, should New York continue to offer a CHPlus "buy-in" option to families with incomes over 400% FPL? Would MOE preclude New York from eliminating this option for families?
	▸ If Federal CHIP funding is eliminated after 2015, how will New York ensure availability of CHPlus benefits to children through 2019?
	▸ Will the State maintain its CHPlus program after 2019 if a fully functioning exchange and/or a Basic Health Program are available to consumers?
	▸ If CHPlus is eliminated in 2015 or 2019, how will New York provide coverage to all immigrant children going forward?

STATE HEALTH INSURANCE EXCHANGES (§§ 1311, 1312, 1313, 1321, 1322, 1323, 1324)

ACA mandates that New York establish by January 1, 2014 an American Health Benefit Exchange (exchange), a marketplace through which individuals and employers may purchase health insurance coverage. Individuals qualified to obtain coverage through the exchange include citizens and legal immigrants who are not incarcerated and do not have access to affordable employer coverage. Small businesses (defined as having up to 100 employees) can obtain coverage for their employees through the exchange. Prior to 2016, states have the option to limit exchanges to businesses with up to 50 employees. Beginning in 2017, states have the option to allow businesses with more than 100 employees to purchase coverage for their employees through the exchange. The exchange will serve as a portal for individuals and employers who are directly seeking health insurance, or for agents or brokers who may act on their behalf. To inform the development of Federal regulations around the exchange, on July 29, 2010, HHS issued a request for comments from states, consumer advocates, employers, insurers, and other interested stakeholders regarding various factors critical to the establishment and operation of the exchange.[29]

Structure and Responsibilities of the Exchange

The State will be responsible for establishing exchange(s) that organize the health insurance market(s) within New York State. Specifically, New York must establish (i) at least one health insurance exchange for individuals who want to enroll in a "qualified health plan" and a separate Small Business Health Options Program (SHOP exchange) for small businesses; or (ii) implement a single exchange that can serve the needs of both individual purchasers and small groups. If the State chooses to merge its individual and Small Group exchange(s), it will have to meet forthcoming HHS standards demonstrating its ability to meet the needs of both the Individual and Small Group markets in a single exchange.

Small Business Tax Credits (§ 1421)

Small business are eligible to apply for new tax credits to offset their premium costs in 2010 if they subsidize, on a uniform basis, at least 50% of the cost of health insurance coverage. Small businesses are defined as those employers with fewer than 25 employees and average wages under $50,000. The credit will be available for up to a two-year period starting in 2010.

The tax credit is paid in full for employers with 10 or fewer full-time equivalent employees (with average wages of $25,000) and phases out as employer size and average wage increases. Between 2010 and 2013, the full credit will cover 35% of a company's premium contribution. Beginning in 2014, the full credit will cover 50% of that contribution.

Tax-exempt organizations will qualify for the credit, although they are lower—25% through 2013 and 35% starting in 2014.

[29] OCIIO-9989-NC on public display at the Federal Register on July 29, 2010.

Exchanges must be managed by a state governmental agency or a nonprofit established by the state and there are numerous models that New York may consider for establishment of its exchange, including: a government agency, an independent nonprofit, a public authority, or a public-private partnership. In 2011, Federal grants will be made available to states to establish the exchanges. The State is obligated to demonstrate an implementation plan for establishing the exchange(s) by January 1, 2013. If New York fails to establish an exchange by January 1, 2014, the Federal government will set up and run a State exchange, either directly or through an agreement with a nonprofit entity.

States have the option of setting up regional exchanges, provided each exchange serves a distinct geographic region. In considering whether to establish regional or statewide exchange(s), the State will need to evaluate regional differences in population, insurance rating, geography, health care delivery system, employer market, and insurance market.

As part of organizing the health insurance market within the State, the exchange will certify for participation "qualified health plans" based on certification criteria established by HHS. ACA appears to provide states with certain flexibility to determine whether the exchange(s) will be structured as a "clearinghouse" model, in which all plans that meet certification requirements are able to obtain qualified health plan status, or an "active purchaser" model that certifies a limited number of health plans for participation in the exchange.[30]

Except for grandfathered plans, all health plans participating in an exchange must operate a single-risk pool for enrollees inside of and outside of the exchange. That is, all of a health plan's enrollees in either the Individual or Small Group market must be treated as a single-risk pool regardless of whether the enrollment occurred within the exchange or not. The ACA also allows the State, at its option, to merge the Individual and Small Group markets into a single-risk pool. Such proposals have been advanced in New York previously as a means to stabilizing the Direct Pay market in the State.[31]

The State exchange will establish a "navigator" program to increase awareness about the exchange and the health insurance subsides newly available to consumers through ACA. The State exchange will further be responsible for: **(i)** determining eligibility for consumer subsidies; **(ii)** the certification process for notifying the Department of Treasury that a consumer is exempt from the individual mandate and/or the penalty; and, **(iii)** providing the employer identification information if an employer penalty needs to be applied.

On January 1, 2015, all exchanges are required to be self-sustaining. Thus, the State will also likely consider administrative economies of scale in developing the exchange(s), including whether certain exchange functions should be centralized and/or outsourced. ACA provides authority for the exchange to outsource administrative functions, including outsourcing eligibility determinations for qualified health plan enrollment, tax credits, and cost-sharing reductions to the State Medicaid agency. The law also allows exchange(s) to charge assessments or user fees to participating insurance issuers or to provide other means of generating revenue.

[30] ACA § 1311.

[31] United Hospital Fund Issue Brief "Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools," 2008.

TABLE 7. Exchange Functions	
PLAN CERTIFICATION & PUBLIC DISCLOSURE	Certify health plans as "qualified health plans" based on Federal requirements.
	Require of plans and make public disclosure of the following information in plain language: claims payment policies and practices; periodic financial disclosures; data on enrollment, denied claims, and rating practices; information on cost-sharing and payments for out-of-network coverage; and enrollee and participant rights.
	Consider premium levels in determining whether to make a plan available through the exchange.
OUTREACH, ENROLLMENT AND EXEMPTIONS	Establish a navigator program to provide public education and outreach designed to promote awareness of the availability of qualified health plans, the premium tax credits and cost-sharing reductions, and to facilitate enrollment in qualified health plans.
	Certify citizenship or immigration status of individuals applying for coverage through the exchange.
	Screen individuals to determine if they qualify for premium tax credits or for coverage under Medicaid or Child Health Plus and if so, enroll them in the appropriate program.
	Certify if an individual is exempt from the individual mandate or the penalty and provide a list of individuals with such certification to the Secretary of the Treasury, including the employer information when an employer penalty needs to be applied.
	Require that qualified plans meet marketing requirements and not use marketing practices or benefit designs that discourage enrollment by high-risk individuals.
	Ensure sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.
	Ensure that plans include in the network those essential community providers, where available, that serve predominately low-income, medically underserved individuals.[32]
CUSTOMER SUPPORT	Maintain an internet website where enrollees and prospective enrollees can obtain standardized information about the plans.
	Operate a toll-free telephone hotline to respond to requests for assistance.
	Establish and make available by electronic means a calculator to determine the actual cost of coverage after accounting for the premium subsidy and the cost-sharing reduction.
QUALITY MEASURES	Assign a rating to each qualified plan offered through the exchange based on criteria established by the Secretary.
	Require plans to implement a quality improvement strategy that uses a payment structure that provides increased reimbursement or other incentives to hospitals and health care providers that improve health outcomes through quality reporting, case management, care coordination, chronic disease management, and care and medication compliance initiatives, including use of a medical home model.

[32] Essential community providers are those "such as health care providers defined in § 340B(a)(4) of the Public Health Service Act and providers described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by § 221 of Public Law 111– 8" and include FQHCs, DSH hospitals, and specialty clinics receiving designated Federal funds, such as those providing family planning services and HIV treatment.

Essential Benefits Package (§ 1302)

Coverage in state exchanges must be offered by qualified health plans that provide a federally mandated "essential benefits package." ACA outlines a basic definition of essential health benefits and requires the Secretary of HHS to further define the essential benefits package. To determine the scope of the essential health benefits coverage, the HHS Secretary must ensure the coverage is equal to the typical coverage provided by an employer, and according to other principles laid out in the Act. Qualified plans are not allowed to design benefits that discriminate against individuals based on age, disability, or expected length of life.

The ACA allows states to require that qualified health plans offer benefits in addition to the essential health benefits defined by the HHS Secretary. However, the state is responsible for defraying the cost of any additional required benefits by making a payment to either: (i) the individual purchasing coverage, or (ii) the qualified health plan in which such individual is enrolled. This provision of ACA has particular relevance in New York, where Insurance Law currently requires all insurers and health plans operating in the State to provide certain "mandated benefits." These mandated benefits vary by type of insurer or plan: group commercial, individual commercial, group HMO, insurers, and individual Direct Pay HMO contracts. A comparison of New York's mandated benefits with ACA essential benefits, provided in the Table below, suggests that certain New York mandates—including home care, durable medical equipment, and chiropractic care—do not appear to be essential health benefits as defined in Federal reform statute (see shaded area of table). For those services that are not essential health benefits pursuant to statute and HHS guidance, New York will have to consider: (i) eliminating its benefit mandates on insurers and plans in the exchange; (ii) maintaining all or some of the State's mandated benefits, but using State dollars to pay for them; or (iii) requiring qualified health plans to offer mandated benefits as supplemental or "rider" coverage to the essential packages as an option for exchange purchasers. The HHS Secretary will release further guidance on the essential health benefits, clarifying the extent to which New York's benefit mandates exceed essential benefits.

TABLE 8. New York State Mandated Benefits Compared to ACA Essential Benefits

ACA ESSENTIAL HEALTH BENEFITS	NEW YORK MANDATED BENEFITS		
	GROUP COMMERCIAL GROUP HMO ARTICLE 43 INSURERS	INDIVIDUAL COMMERCIAL	INDIVIDUAL DIRECT PAY HMO
AMBULATORY PATIENT SERVICES	Bone density measurements, testing, drugs, and devices		Outpatient hospital services Chemotherapy services Hemodialysis services Bone density measurements, testing, drugs and devices
EMERGENCY SERVICES	Emergency medical services Pre-hospital emergency medical services	Emergency medical services Pre-hospital emergency medical services	Emergency medical services provided in a hospital
HOSPITALIZATION	Preadmission testing Second surgical opinion Mastectomy care Second medical opinion for cancer diagnosis Post-mastectomy reconstruction End of life care	Preadmission testing Second surgical opinion Mastectomy care Second medical opinion for cancer diagnosis Post-mastectomy reconstruction End of life care	Inpatient hospital services, including room & board and nursing care Second surgical opinion Mastectomy care Second medical opinion for cancer diagnosis Post-mastectomy reconstruction Preadmission testing End of life care
MATERNITY AND NEWBORN CARE	Maternity care	Maternity care	Maternity care
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT	Chemical abuse and dependence (outpatient) Mental, nervous or emotional disorders, or ailments Biologically based mental illness and serious emotional disturbances		Inpatient mental health care Outpatient mental health Inpatient alcoholism and substance abuse
PRESCRIPTION DRUGS	Enteral formula Cancer drugs Contraceptive drugs and devices	Enteral formula Cancer drugs	Blood and blood products Pharmacy and mail order Enteral formulas, cancer drugs, contraceptive drugs and devices
REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES			Outpatient physical therapy Inpatient physical rehabilitation services
LABORATORY SERVICES			Diagnostic laboratory services Radiology services
PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT	Diabetes supplies, equipment, and self-management education Preventive and primary care Mammography screening Prostrate cancer screening Cervical cytology screening	Diabetes supplies, equipment, and self-management education Preventive and primary care Mammography screening Prostrate cancer screening Cervical cytology screening	Periodic physical exams Mammography screening Cervical cytology screening Immunizations Diabetes supplies, equipment, and self-management education

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TABLE 8. New York State Mandated Benefits Compared to ACA Essential Benefits

(CONTINUED) PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE	Autism spectrum	Autism spectrum	Well child care
	Home health care	Home health care	Home health care
	Medical conditions leading to infertility	Medical conditions leading to infertility	Hospice care
	Chiropractic care	Chiropractic care	Skilled nursing facility care
	Experimental services recommended by external review agent	Experimental services recommended by external review agent	Ambulance services
	Infertility coverage		Private duty nursing
	Eating disorders		Durable medical equipment
			Experimental services recommended by external review agent
			Eating disorders

Source: Mandated and Make Available Benefits for Commercial, HMO & Article 43 Insurance Contracts: http://www.ins.state.ny.us/health/lbenall.pdf. Accident and Health Product Checklists and Outlines: http://www.ins.state.ny.us/a&hpock.htm.

Exchange benefit levels are based on comprehensiveness of benefits and consumer cost-sharing for a typical or standard population. The ACA imposes a limit on out-of-pocket costs, such as co-payments and deductibles, of $5,950 for individuals and $11,900 for families purchasing coverage through the exchange.[33] For those with modest incomes, premium tax credits and further reductions in cost-sharing levels will be made available (discussed below). The ACA establishes four categories for essential benefits levels—Bronze (minimum coverage), Silver, Gold, and Platinum—that cover the same set of services but range in the value of benefits covered.

FIGURE 1. Health Coverage through the Exchange: Essential Benefits Package

REQUIRED SERVICES:	"ACTUARIAL VALUE"—PORTION OF HEALTH CARE COSTS COVERED BY PLAN FOR A STANDARD OR TYPICAL POPULATION			
	PLATINUM	GOLD	SILVER	BRONZE
Ambulatory patient services	90%	80%	70%	60%
Emergency services				
Hospitalization				
Maternity and newborn care				
Mental health and substance use disorder services, including behavioral health treatment				
Prescription drugs				
Rehabilitative and habilitative services and devices				
Laboratory services				
Preventive and wellness services and chronic disease management				
Pediatric services, including oral and vision care				
Limits on out-of-pocket costs for all categories of essential benefit levels (levels further reduced for individuals with incomes between 100% and 400% FPL enrolled in a Silver tier plan)	Individuals: $5,950 Families: $11,900			

[33] Out-of-pocket limits are aligned with Federal high-deductible plan out-of-pocket spending limits, which are re-indexed annually. The figures expressed are 2010 levels.

Qualifying insurers must offer at least one plan at the Silver and one plan at the Gold level in each exchange where their plans are offered. Qualifying plans must offer a child-only policy for any of the four categories of benefits it offers.

Qualifying plans may offer catastrophic coverage that does not meet one of the four levels of coverage, but only to enrollees aged 30 or under and those who would otherwise be exempt from the requirement to purchase coverage because the lowest cost premium exceeds 8% of their income. These plans would offer less coverage at a lower premium, as set by the HSA current law levels. Prevention benefits and coverage for three primary care visits would be exempt from the deductible.

Subsidies (§§ 1401, 1402, 1411, 1412)

Beginning in 2014, the insurance exchange(s) will administer a subsidy program including premium tax credits and cost-sharing assistance. Refundable and advanceable premium tax credits will be based on a comparison of (i) a taxpayer's monthly household income as a percentage of the Federal poverty level to (ii) the monthly premium for the second lowest cost plan within the "Silver" tier. Individuals with incomes up to 400% FPL will receive a tax credit for a percentage of the cost of premiums for coverage under a qualified health plan. Premium tax credits are scaled by family income so that premiums are less than 2% of income for consumers with incomes up to 133% FPL while households with incomes 300–400% FPL would not pay more than 9.5% of income for health insurance. The ACA also provides that lower income people have their out-of-pocket spending capped at lower levels if they choose a Silver level plan, which has the effect of increasing the actuarial value of their health plan (i.e., the plan pays a higher proportion of the cost of benefits).

In New York, there has been considerable concern among State officials, consumer advocates, and other stakeholders that the national standard subsidies prescribed by the ACA will be insufficient to allow consumers to purchase coverage. Consumers in New York and other high cost-of-living states have less disposable income to purchase health insurance coverage, perhaps even subsidized coverage. Recognizing the variation in cost-of-living among states, the ACA requires the Secretary of HHS to conduct a study to examine the feasibility of adjusting FPL levels for the purposes of determining subsidies and cost-sharing for different geographic areas.[34] The law states that if HHS determines that an adjustment is feasible, the study should include a methodology to make such an adjustment. The Secretary is required to submit a report to Congress by January 1, 2013.

[34] § 1416, as added by § 10105(f).

TABLE 9. ACA Premium Subsidy Levels (Income Level Premium as a Percent of Income)	
Up to 133% FPL	2% of income
133–150% FPL	3–4% of income
150–200% FPL	4–6.3% of income
200–250% FPL	6.3–8.05% of income
250–300% FPL	8.05–9.5% of income
300–400% FPL	9.5% of income

Source: Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies", April 2010. http://www.kff.org/healthreform/7962.cfm.

In general, subsidies will not be available to people with access to health coverage through an employer. If an employer health plan does not have an actuarial value of at least 60%—meaning that the plan covers at least 60% of the cost of covered benefits in the aggregate for a standard population—or if an employee's share of the employer premium exceeds 9.5% of income, the employee may enroll in a plan in the exchange and be eligible for premium and cost-sharing subsidies. Employers offering minimum essential coverage will be required to provide "free choice vouchers" to employees with incomes less than 400% FPL and whose contribution for the employer coverage exceeds 8%, but does not exceed 9.8% of their income, which they can use to enroll in an exchange.

TABLE 10. ACA Cost-Sharing Reductions for Lower-Income Families	
INCOME LEVEL	REDUCTION IN OUT-OF-POCKET COSTS FOR A SILVER TIER PLAN
100%–200% FPL	2/3 of the maximum
200%–300% FPL	1/2 of the maximum
300%–400% FPL	1/3 of the maximum

Source: Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," April 2010. http://www.kff.org/healthreform/7962.cfm.

The exchange must establish, and make available by electronic means, a calculator to determine the actual cost of coverage after any premium tax credit and cost-sharing reductions are applied. The tool will help purchasers understand the actual costs of obtaining health insurance inside the exchange.

Although there is a presumption that the advanced determination of subsidies and the other enrollment-related processes described above will be performed by the exchange, ACA provides the State with the flexibility to operate the enrollment and eligibility determination program as part of its Medicaid program.

The State must operate the exchange as part of a coordinated system with other "state health subsidy programs." Thus, individuals must be able to apply for enrollment and receive a determination of eligibility to participate (or continue to participate) in premium tax credits and cost-sharing reductions within the exchange, the State Medicaid program, CHPlus and the Basic Health Program, should the State develop one.

Qualified Health Plans (§ 1301)

HHS will develop a regulation that addresses the requirements that an exchange will use in certifying a health plan as a qualified health plan. ACA requires that "at a minimum" the qualified plans offered inside the exchange:

- Offer essential benefit packages with cost-sharing levels and actuarial values consistent with ACA requirements.
- Meet marketing requirements and not use marketing practices or benefit designs that discourage enrollment by high-risk individuals.
- Ensure sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.
- Include in the network those essential community providers, where available, that serve predominately low-income, medically underserved individuals.[35]
- Be accredited with respect to local performance on clinical quality measures, patient experience ratings, and other accreditation program requirements.
- Implement a quality improvement strategy, which uses a payment structure that provides increased reimbursement or other incentives to hospitals and health care providers that improve health outcomes through quality reporting, case management, care coordination, chronic disease management and care and medication compliance initiatives, including use of a medical home model.
- Use a "uniform enrollment form" developed by the National Association of Insurance Commissioners (NAIC) and certified by HHS.
- Use standard format established for presenting health benefit plan options.
- Provide information to enrollees and prospective enrollees and to each exchange in which the plan is offered on any quality measures.

In some states, newly established co-op plans may be a source of qualified health plans offered through the exchange (see box).

Consumer Operated and Oriented Plans (§ 1322)

ACA appropriates $6 billion to establish nonprofit, member-run health insurance companies through the Consumer Operated and Oriented Plan (co-op) program, in each state to offer qualified health plans for Individual and Small Group markets. Co-ops are consumer-governed organizations that provide insurance and deliver health services.

Advisory Board: In June 2010, the Comptroller General of the U.S. established an Advisory Board with 15 appointed members. The HHS Secretary is required to award loans and grants for the nonprofit plans based on Board recommendations no later than July 1, 2013. ACA directs the Secretary to give preference in awards to applicants that will offer a qualified plan on a statewide basis, will utilize integrated care models, and have private support. The grants will be available to new co-ops. ACA also directs the Secretary to ensure that there is funding to establish at least one co-op per state.

[35] Essential community providers are those "such as health care providers defined in § 340B(a)(4) of the Public Health Service Act and providers described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by § 221 of Public Law 111– 8.

STATE IMPLEMENTATION: CHART 5. Health Insurance Exchange	
SUMMARY	Creates state-based exchanges to assist individuals and small businesses in obtaining health insurance. The exchanges must be run by a governmental agency or a nonprofit entity established by a state. Coverage in the exchanges must be offered by "qualified health plans," private plans that must provide a set of federally mandated services called an "essential benefits package" with four benefit levels. Out-of-pocket costs are capped and for those with modest incomes, premium tax credits, and reductions in cost-sharing levels will be available.
EFFECTIVE DATES	**September 30, 2010:** Initial Exchange Planning and Establishment grants of up to $1 million are anticipated to be awarded. Planning grants may be renewed; grant funding ends January 1, 2015.
	July 1, 2013: States have an option to form interstate compacts to facilitate the purchase of health insurance effective July 1, 2013.
	January 1, 2013. States must demonstrate to the Secretary that they have taken actions necessary to implement the exchange(s) by January 1, 2014.
	January 1, 2014: Exchanges must be operational. If a state fails to have an operational exchange by January 1, 2014, the Federal government, through HHS, will establish an exchange in that state.
	January 1, 2015: Date by which each exchange is required to be self-sustaining (assessments and user fees on insurance issuers are permitted).
	January 1, 2017: States have an option to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange(s).
FEDERAL FUNDING	Exchange Planning and Establishment grant funding in amounts to be determined by HHS is available to help states establish exchanges within one year of enactment and until January 1, 2015. HHS recently issued a funding opportunity announcement to make available an initial installment of up to $1 million to each state.[36]
RESPONSIBLE PARTIES	▸ HHS is responsible for launching a consumer Web portal, issuing grants to support fund exchanges and, establishing the Federal requirements for state exchanges.
	▸ The New York State Insurance Department and the New York State Department of Health are responsible for planning and implementing the exchanges, including crafting conforming regulations required to operate the exchanges.
	▸ The New York State Legislature will enact any legislation required to operate an exchange consistent with, but not limited to, the Federal requirements.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Respond to funding opportunity announcement to help plan and establish the exchanges.
	▸ Determine structure and governance of exchange and model for "organizing the insurance market."
	▸ Define risk-adjustment mechanisms.
	▸ Establish rating areas and a rating framework.
	▸ Conduct inventory of existing IT/systems, identify requirements for establishing the exchanges, and develop the required infrastructure.

continued on next page ▶

[36] State Planning and Establishment Grants for the Affordable Care Act's Exchanges, Catalog of Federal Domestic Assistance (CDFA) Number 93.525.

STATE IMPLEMENTATION: CHART 5. Health Insurance Exchange

(CONTINUED)

STATE IMPLEMENTATION TASKS/ISSUES

Tasks
Apply mental health parity provisions to qualified health plans.
Develop provider network standards.
Establish marketing standards.
Develop premium subsidy mechanism.
Plan billing procedures and responsibilities (exchange vs. insurer)
Build eligibility determination process, including assessment of income, access to employer-sponsored insurance, and citizenship status.
Establish co-op structure.
Demonstrate implementation readiness to HHS.
Issues
How much additional capital will the State need to develop and launch the exchange and how will it be funded?
Will New York's exchange be part of State government agency, an independent nonprofit organization, a public authority, or a public/private partnership?
Will New York establish one exchange? Independent exchanges for individuals and small businesses? Regional exchanges in New York City and other parts of the State? If multiple exchanges are established, how will they relate to one another?
Should New York merge its Individual and Small Group markets into a common risk pool in the exchange? Outside of the exchange? Will a merged market outside the exchange stabilize the existing Direct Pay pool? Will a merged market in the exchange avoid replication of market segmentation issues?
Will New York's exchange be a "clearinghouse" model or an "active purchaser" model?
Will all plans in the exchange be required to offer individual, small business, and public health insurance products?
How will the exchange ensure seamless transitions from Medicaid, the Basic Health Program—if it is established—and private health insurance options?
Will New York maintain and subsidize current mandated benefits that are over and above essential benefits?
How will New York's exchange administer abortion coverage?
Which exchange functions, if any, will be outsourced? Will the exchange outsource subsidy eligibility determinations to the Medicaid program?
Is it necessary for New York to maintain a Direct Pay market outside of the exchange to provide coverage access for undocumented individuals?
How will private market products that are not "creditable coverage" under the ACA be handled?

Technical and Financial Consumer Assistance

Health Insurance Consumer Information (§ 1002). The State, or a State-established exchange, will be eligible to receive grant funds to expand existing—or establish new—independent offices of health insurance consumer assistance or health insurance ombudsman programs. These offices would be charged with collaborating with state insurance regulators and consumer assistance organizations to respond to inquiries and complaints concerning health insurance coverage. A total of $30 million in Federal grant funding is available for this purpose during the first year (2011), with further funding subsequently available in amounts to be determined in the Congressional appropriations process. On July 22, 2010, HHS's Office of Consumer Information and Insurance Oversight (OCIIO) released a funding opportunity announcement (FOA) for the first year of funding. The deadline for responses is September 10, 2010, with decisions on awards anticipated by October 8, 2010.[37]

STATE IMPLEMENTATION: CHART 6. Health Insurance Consumer Assistance	
SUMMARY	The State may be able to access Federal funding to support an existing, or establish a new, independent consumer assistance office.
EFFECTIVE DATE	March 23, 2010
FEDERAL FUNDING	▸ $30 million in 2011.
	▸ $340 million between 2012 and 2019 (subject to appropriation).
RESPONSIBLE PARTIES	▸ HHS released a Funding Opportunity Announcement (FOA) on July 22, 2010 for the first year of funds.
	▸ The New York State Department of Health and the State Insurance Department will determine whether New York will request funding to establish a consumer assistance office through a State agency, the State exchange, and/or contracts with independent consumer assistance entity or entities in the State.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Respond to funding opportunity announcement to help plan and establish the exchanges.
	▸ Determine model and structure of consumer assistance program.
	Issues
	▸ Will New York's consumer assistance program be part of a State agency, such as the New York State Department of Health or the State Insurance Department, part of the exchange, or part of an independent entity?

Consumer Information Portal (§ 1103). The ACA requires that HHS establish a mechanism to help consumers identify affordable health coverage options, including an Internet website, by July 1, 2010. HHS issued interim final regulations, effective May 10, 2010, to begin implementation of the portal.[38] On June 30, 2010, HHS unveiled the new website, www.healthcare.gov, with search capacity for consumers to identify health insurance options in their geographic regions. The website also includes updates on implementation of the ACA. HHS intends to continue to develop website information, including insurance premium pricing data, as plans and states submit required data to the agency.[39] In 2014, this website will be coordinated with the website the state is charged with developing under the exchange.

[37] Affordable Care Act – Consumer Assistance Grants, CDFA Number 53.519.

[38] 75 Federal Register 24470-24482.

[39] http://www.healthreformgps.com/.

Navigators (§ 1311(i)). Effective January 1, 2014, the ACA requires that the State exchange establish a grant program to award funding to entities that will provide consumers with information and assistance with respect to enrolling in health insurance coverage. Specifically, navigators will:

- conduct public education activities to raise awareness of the availability of qualified health plans;
- distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits to offset the cost of coverage;
- facilitate enrollment in qualified health plans;
- provide referrals to consumer assistance and ombudsman programs for assistance with grievances, complaints, or questions regarding coverage; and
- provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

Entities eligible to serve as navigators include those that have existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. Such entities may include trade, industry, and professional associations; community and consumer-focused nonprofit groups; chambers of commerce; unions; and licensed insurance agents and brokers. Health insurance issuer and entities that receive consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals are not permitted to serve as navigators. Navigator grants must be made from the operational funds of the exchange and not Federal funds received by the State to establish the exchange.

New York State already has a significant network of "navigator-like" entities operating throughout the State, including community-based organizations, consumer assistance programs, Maximus, and facilitated enrollers (FEs) (with Maximus and FEs exclusively providing services to consumers eligible for the State's public insurance programs). The State's large network of FEs currently conduct eligibility screening and application assistance for the vast majority of Medicaid, CHPlus, and FHPlus enrollees in New York, and comprise both community-based organizations and health plans. The ACA would appear to prohibit health plan FEs from becoming navigators in 2014; it is unclear whether the State will be permitted and will elect to maintain the FE program for the State's public programs.

BASIC HEALTH PROGRAM (§ 1331)

The ACA gives the State the option to establish a "Basic Health Program" through which it may enter into contracts with health plans to provide essential health benefits to individuals with incomes above the new Medicaid threshold of 133% FPL and up to 200% FPL who would otherwise access coverage through the State exchange. Basic Health Program eligible individuals will be required to enroll in the program; they are not permitted to enroll in subsidized private coverage through the exchange. The HHS Secretary is responsible for establishing the Basic Health Program through Federal regulation. New York State may

consider a Basic Health Program a means to providing an affordable coverage option for families with incomes between 134% and 200% FPL, many of whom are covered today in New York's Family Health Plus and Child Health Plus programs.

Coverage for Legal Immigrants

ACA does not lift the required five-year waiting period ("five-year bar") that legal immigrants who are non-pregnant adults must fulfill to access Federal, means-tested benefits, like Medicaid. However, as a result of Federal health reform, legal immigrants under the five-year bar will have other coverage options during the waiting period available through the exchange or the Basic Health Program.

- All legal immigrants will be able to access coverage under the exchange, as well as applicable premium tax credits and cost-sharing reductions in the same manner as citizens. Though premium tax credits and cost-sharing reductions are generally only available for individuals between 100% and 400% FPL, ACA further allows for legal immigrants with incomes under 100% FPL, and who are under the five-year bar, to access subsidies comparable to an individual with income of 100% FPL.
- All legal immigrants between 133% and 200% FPL will be able to access Basic Health Program coverage (if the State chooses to implement the program). Though Basic Health Program coverage is generally limited to the 133-200% FPL income bracket, ACA further allows legal immigrants under 133% FPL and who are under the five year bar to access Basic Health Program coverage.

New York State currently covers all legal immigrants, including those who are Permanently Residing Under Color of Law (PRUCOL) and residing for fewer than five years, in State public insurance programs. If HHS does not include all PRUCOLs in its definition of lawfully residing, it will raise questions with respect to New York's obligation to provide access to the high-risk pool, the exchange and a Basic Health Program for these individuals.

Eligible Individuals. Pursuant to ACA, citizens and legal immigrants under the age of 65 and with household incomes between 134% and 200% FPL would be eligible to enroll in the Basic Health Program. Legal immigrants with incomes less than 133% FPL, and who are not eligible for Medicaid because of the five-year waiting period, are also eligible to participate in the Basic Health Program.[40]

Consumer Cost-Sharing. ACA establishes monthly premiums for the Basic Health Program at the level of the second lowest cost coverage option ("Silver Program") offered in the State exchange. Additionally, cost-sharing for beneficiaries with family income between 134% and 150% FPL may not exceed the cost-sharing required under the most generous coverage option in the State exchange (a "Platinum Program"). Cost-sharing for beneficiaries with family incomes between 151% and 200% FPL may not exceed the cost-sharing required under a Gold Program (see page 20. State Health Insurance Exchanges, above, for a discussion of the categories of coverage required in the exchange).

Standard Health Plans. ACA requires the State to establish a competitive contracting process for standard health plans, which may include licensed health maintenance organizations, licensed health insurance insurers, or networks of health care providers established to offer services under the Basic Health Program. The law specifically directs that the State should consider the following

[40] Public Laws 111-148 & 111-152: Section 10104.

factors (in addition to negotiation of premiums, cost-sharing, and benefits) in its contracting process:

- Negotiation with plans that offer (i) care coordination and care management, especially for chronic conditions; (ii) incentives for use of preventive services; and (iii) establishment of provider/patient relationships that maximize patient involvement in health care decision making.
- Contracting with managed care systems or systems that offer attributes of managed care.
- Establishing quality of care and outcome measurement and reporting requirements.
- Making multiple standard health plans available through the Basic Health Program.

Funding. If a state offers a Basic Health Program, ACA requires the Secretary to transfer to that state 95% of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans through the exchange. In turn, the State is required to establish a trust for deposit of Federal Basic Health Program funds. ACA requires that these funds be used only to reduce premiums and cost-sharing for eligible individuals or to provide additional benefits.

STATE IMPLEMENTATION: CHART 7. Basic Health Program	
SUMMARY	The State has the option of creating a Basic Health Program for all people under age 65 with incomes between 134% and 200% FPL and legal immigrants below 133% FPL who are ineligible for Medicaid because of the five-year bar. Funding for the program would come from Federal dollars that would otherwise have supported tax credits and cost-sharing reductions had these New Yorkers enrolled in coverage through the State exchange.
EFFECTIVE DATE	January 1, 2014
RESPONSIBLE PARTIES	▸ The Department of Health and Human Services is responsible for issuing guidance on the Basic Health Program.
	▸ The Secretary will develop the methodology for transferring funds to states. The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, will certify the methodology.
	▸ The New York State Insurance Department and the New York State Department of Health have the option of establishing a Basic Health Program to provide comprehensive coverage for low-income families.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Determine whether New York State will establish the Basic Health Program and develop and implement the program consistent with Federal guidance.
	Issues
	▸ Can a Basic Health Program provide a cost-effective and comprehensive coverage option for families with incomes from 134%–200% FPL?
	▸ Will persons permanently residing under the color of law (PRUCOLs) have access to the Basic Health Program?
	▸ Beyond essential benefits, what benefit package will New York be able to buy for a Basic Health Program?

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STATE IMPLEMENTATION: CHART 7. Basic Health Program	
STATE IMPLEMENTATION TASKS/ISSUES (CONTINUED)	▸ How much funding will be available through the 95% tax credit to offset the cost of a Basic Health Program?
	▸ Will New York subsidize the Basic Health Program by transferring dollars currently used to fund coverage for individuals above 133% FPL in its existing public health insurance programs?
	▸ What is the risk profile of those eligible for the Basic Health Program? How does the risk profile impact Basic Health premiums? What are the related implications for the exchange risk pool?
	▸ How will Basic Health Program reimbursement be structured?
	▸ Will the Basic Health Program be a managed care product?
	▸ How will a seamless transition be ensured among Medicaid, the Basic Health Program, and private health insurance?

INDIVIDUAL AND EMPLOYER MANDATES

ACA requires that all individuals have at least minimum essential health insurance coverage through a qualified health plan starting in 2014. Minimum essential coverage includes government-sponsored coverage, employer-sponsored care, grandfathered health plans, and plans offered in the individual market. A qualified health plan provides the essential health benefits package, limits annual cost sharing to the high-deductible health plan limit, limits the annual deductible for Small Group market plans to $2,000 (individual) and $4,000 (families), and does not require cost-sharing for preventive services or immunizations. Catastrophic coverage will be available for individuals under the age of 30 and for those who qualify for an affordability exemption from the requirement to purchase coverage.

Businesses and governmental entities that employ more than 50 employees have mandated responsibilities in supporting their employees' access to affordable coverage or to provide coverage, depending on size. Self-employed individuals are also required to purchase health insurance and have the option to do so through the insurance exchanges. Individuals and businesses that fail to comply with the new regulations are subject to annual penalties, described in more detail below.

Individual Responsibility (§ 1501 (as modified by § 10106 and § 1002 of HCERA))

In 2014, every person—including dependents—must have either public or private health insurance or face an annual fine. ACA provides limited hardship and religious exceptions,[41] as well as an affordability exemption for individuals for whom the cost of coverage exceeds 8% of their annual income. Those with incomes below the tax filing threshold of 100% FPL (in 2009 the threshold

[41] The requirement is not applicable to individuals with a religious conscience exemption, defined as those with a certification under § 1311 as a member of a recognized religious sect that qualifies for exemption from self-employment taxes and as an adherent of established tenets or teaching of such sect; individuals not lawfully present in the U.S.; Native Americans; and individuals who are incarcerated other than incarceration pending disposition of charges.

for taxpayers under age 65 was $9,350 for singles and $18,700 for couples) are also exempt from the requirement and associated penalties. Failure to obtain minimum essential coverage after January 1, 2014 will result in a penalty that scales up over time:

- 2014: $95 or 1% of MAGI (whichever is greater)
- 2015: $325 or 2% of MAGI (whichever is greater)
- 2016: $695 or 2.5% of MAGI (whichever is greater)
- 2017 and beyond: prior year's penalty subject to inflation

STATE IMPLEMENTATION: CHART 8. Requirement to Maintain Minimum Essential Coverage	
SUMMARY	Requires individuals to have and maintain health coverage, or face income-based penalties. Penalties are the greater of a flat fee or a percentage of income. Exempts from the mandate and associated penalties undocumented immigrants, American Indians, those with a religious conscience objection, and those who do not meet income tax filing threshold or for whom affordable coverage is not available. Coverage is considered unaffordable if it exceeds 8% of an individual's income.
EFFECTIVE DATE	January 1, 2014
RESPONSIBLE PARTIES	▸ Secretary of HHS.
	▸ Department of Treasury.
	▸ State exchange will be responsible for the certification process by which the Department of Treasury will be notified that an individual is exempt from the individual mandate and penalty.

Employer Responsibilities (§ 1513 (as modified by § 10106 and § 1003 of HCERA))

ACA requires that all employers with more than 50 employees offer qualified coverage to their employees, and employers with more than 200 employees automatically enroll all new employees in a health care coverage plan. Employers with more than 50 employees that do not offer qualified coverage and have at least one employee receiving a premium assistance tax credit will be fined $2,000 multiplied by the number of their employees (but the first 30 employees will not be counted toward the penalty calculation). The employer responsibilities under the health reform law do not apply to employers with fewer than 50 employees.

The ACA also requires that employers that offer minimum essential coverage to their employees provide a "free choice voucher" to employees with household incomes up to 400% FPL whose premium share of the employer sponsored coverage is unaffordable (between 8% and 9.8% of their income.) Free vouchers may be used by such employees to purchase more affordable coverage in the exchange. Employers will not be penalized for employees using free choice vouchers to enroll in coverage through the exchange.

STATE IMPLEMENTATION: CHART 9. Shared Responsibility for Employers	
SUMMARY	Requires that large employers (>50 employees) that do not offer minimum essential coverage and have at least one employee who receives a premium assistance tax credit through the exchange pay $2,000 for each full-time employee, excluding the first 30 employees from the assessment.
	Requires that large employers that do offer coverage, but have at least one employee who receives a premium assistance tax credit through the exchange, pay the lesser of:
	▸ $3,000 per employee receiving a premium assistance tax credit; or
	▸ $2,000 per full-time employee, excluding the first 30 employees from the assessment.
	Requires that employers provide information to employees at the time of hire (and current employees by March 1, 2013) about:
	▸ the health insurance exchange;
	▸ availability of premium tax credits in the exchange for employees with employers that offer coverage, but pay less than 60% of the premium; and
	▸ loss of employer contribution if consumer purchases a qualified health plan through the exchange.
	Requires that employers provide free choice vouchers to eligible employees.
EFFECTIVE DATE	January 1, 2014
RESPONSIBLE PARTIES	▸ Secretary of HHS.
	▸ Department of Labor.
	▸ Department of Treasury.
	▸ State exchange will be responsible for the certification process by which the Department of Treasury is notified of employer identification information if an employer penalty needs to be applied.

PRIVATE COVERAGE PROVISIONS

The ACA enacts private health insurance reforms to address consumer barriers to comprehensive coverage, establishes insurance industry standards and new consumer protections, and provides outreach and tax subsidy mechanisms targeted to connecting individuals and Small Group employers to insurance coverage. New standards and requirements for health plans and insurers will require New York State to harmonize its existing regulations and oversight activities with Federal requirements in numerous areas, including premium review and approval, plan financial reporting, product design, and network development. Some of ACA's requirements become effective in the short term (immediately or by September 2010) and others in the longer term (through 2014). Additional Federal guidance is anticipated on a number of private insurance reforms and will inform the State's implementation of the law.

Temporary High-Risk Pool Program (§ 1101)

ACA provides $5 billion in funding to establish a national network of insurance pools for citizens and legal immigrants who have pre-existing conditions and have been uninsured for at least six months. The temporary high-risk pools are intended to open within 90 days of enactment of ACA and run until 2014, when new regulations that prohibit insurance companies from denying coverage to individuals based on pre-existing conditions take effect. The new temporary high-risk pool program is meant to serve as a bridge to the establishment of the exchanges; it will operate until January 1, 2014. States will be expected to transition the high-risk pool enrollees to the state exchanges by January 1, 2014.

At least 35 states[42] already have some form of a high-risk pool, though many have struggled with higher-than-average premium costs and underfunding.[43] New York has an open enrollment and pure community rating model (no one is rejected or required to pay more because they are high-risk), which in the individual market, exists in lieu of a high-risk pool. The ACA high-risk pool program is a state option; the law provides that the Federal government will run the high-risk program in states that opt not to implement one. On April 30, Governor Paterson indicated to U.S. Department of Health and Human Services Secretary Kathleen Sebelius that New York State will establish its own state-based high-risk pool in line with the health reform regulations.[44] On July 1, 2010, New York submitted to HHS its application for high-risk pool formation and funding.[45]

Risk Pool Structure. New York proposes to establish its high-risk pool through a third-party administrator contract with a single, statewide health plan contractor, GHI, Inc. While New York has designated GHI as the high-risk pool contractor, the Federal government, and not the State, will hold the contract with the plan. A memorandum of understanding among HHS, New York State, and GHI will be executed, through which the State Insurance Department will be designated as the high-risk pool regulator.

Eligibility. ACA eligibility criteria for high-risk pool enrollment include the following, although the law appears to give states flexibility to impose additional eligibility criteria:

- ***Citizenship or immigration status as a national of the United States or lawfully present in the United States.*** New York does not currently impose a citizenship test in its Direct Pay insurance market. Additionally, New York case law prohibits discriminatory eligibility practices that prevent legal immigrants, including those Permanently Residing Under the Color of Law (PRUCOL), from applying for and receiving coverage in public health insurance programs.[46]

[42] "Health Insurance: Enrollment, Benefits, Funding and Other Characteristics of State High-Risk Health Insurance Pools," GAO-09-730R, U.S. Government Accountability Office, July 22, 2009.

[43] "Health Reform Implementation Begins with High-riskHigh-risk Pools," PBS Newshour, April 2, 2010.

[44] New York State, Office of the Governor (April 30, 2010). "Governor Paterson Announces New York to Participate in High-risk Pool Under Federal Health Care Reform." http://www.state.ny.us/governor/press/043010HighRiskPool.html. Retrieved 05-07-2010.

[45] "Governor Paterson Announces State Application to Participate in Pre-Existing Condition Insurance Plan Press Release, Office of New York State Governor David Paterson, July 1. 2010. http://www.state.ny.us/governor/press/070110Insurance.html.

[46] *Aliessa v Novello*, 96 NY2d 418 [2001].

In its high-risk pool application to HHS, New York has proposed to include all categories of lawfully present immigrants who are currently deemed eligible for the State's Medicaid program, pursuant to State law. If HHS does not accept New York's proposal to include all PRUCOLs in its definition of lawfully residing, it may raise questions regarding New York's constitutional obligation to provide access to the high-risk pool for these individuals.

- ***No coverage under creditable coverage (as defined in § 2701(c)(1) of the Public Health Service Act)*** for the previous six months before applying for high-risk pool enrollment. New York currently does not have a waiting period for coverage in its Direct Pay market. The State does have a waiting period for enrollment in the Healthy New York program, with waiting period exceptions for involuntary loss of prior insurance. In its high-risk pool application, New York proposes to create similar waiting period exceptions.
- ***A pre-existing condition***, as determined in a manner consistent with guidance issued by the Secretary. New York does not currently impose a pre-existing condition exclusion in its Direct Pay market.

An implementation issue implicit to all of these eligibility requirements is whether beneficiaries will be required to prove their eligibility, or HHS will permit New York to allow beneficiary attestation of eligibility criteria, as proposed in its high-risk pool application to HHS.

Benefits. New York's high-risk pool application proposes a comprehensive benefit package provided through a preferred provider organization or "PPO" benefit model—beneficiaries might seek providers and services outside of the "preferred network" for additional cost-sharing.

TABLE 11. New York State High-Risk Pool Proposed Benefit Package

BENEFIT	LIMITATIONS	IN-NETWORK CO-PAYMENTS
Inpatient Hospital Services		
Inpatient Hospital Coverage		$500 co-pay
Skilled Nursing Facility Care		Covered in full
Inpatient Medical Rehab	30 days per calendar year	$500 co-pay
Hospice	210 days per lifetime	Covered in full
Outpatient Services		
Pre-admission testing		Covered in full
Ambulatory surgery		$250 co-pay
Home health care	200 visits per calendar year	Covered in full
Diagnostic lab and radiology	Pre-certification required for radiology services	Covered in full
Preventive mammography, PAP smear, and prostate screening		Covered in full
Physician/Other Provider Services		
Office visit		$20 co-pay
Specialist office visits		$20 co-pay
Maternity pre/post-natal care		Covered in full
Annual physical		Covered in full

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TABLE 11. New York State High-Risk Pool Proposed Benefit Package

BENEFIT	LIMITATIONS	IN-NETWORK CO-PAYMENTS
(CONTINUED)		
Physician/Other Provider Services		
Preventive mammography, PAP smear, and prostate screening		Covered in full
Chiropractic care		$20 co-pay
Physical therapy/occupational therapy	30 visits per calendar year	$20 co-pay
Speech therapy	10 visits per calendar year	$20 co-pay
Outpatient surgery		Covered in full
Inpatient surgery		Covered in full
Durable medical equipment		Covered in full
Diagnostic lab	Provider's office/freestanding facility	Covered in full
Diagnostic radiology	Provider's office/freestanding facility Pre-certification required, in-network only	Covered in full
Well baby and child care	Up to age 19	Covered in full
Emergency Coverage		
Emergency room	Co-pay waived if admitted	$100 co-pay
Emergency transportation		Covered up to $100 of usual and customary
Inpatient Mental Health/Chemical Dependence Services		
Inpatient mental health	30 days per calendar year, no limits for biologically based illness	$500 co-pay
Chemical dependence detox	7 days per calendar year	$500 co-pay
Chemical dependence rehab	30 days per calendar year	$500 co-pay
Outpatient Mental Health/Chemical Dependence Services		
Outpatient chemical dependence	60 visits per calendar year, up to 20 family visits	Covered in full
Outpatient mental health	30 visits per calendar year, no limits for biologically based illness	$20 co-pay
Vision		
Exam	Davis vision providers only One eye exam biennially	$10 co-pay
Prescription Drugs		
Prescription drugs		$0 retail co-pay for generic
		$10 retail co-pay for formulary brand
		$0 mail order co-pay for generics
		$20 mail order co-pay for formulary brand
		Mandatory generic and mail order apply

Source: New York State Department of Insurance

Pursuant to the ACA, this benefit package was designed to cover at least 65% of health care costs (i.e., beneficiary cost sharing cannot exceed 35%) and limit out-of-pocket expenses to be no greater than $5,950 for individual and $11,900 for family coverage in 2010. The Secretary may modify the out-of-pocket limit as necessary to ensure the pool meets the actuarial limit of 65%. The provision sets pool premiums as if for a standard population and not for a population with a higher health risk, though allows premiums to vary by age (4:1), tobacco use (1.5:1), geographic area, and family composition. Finally, the Federal application solicitation for state high-risk pools stipulates that state pools must include medical management as part of the benefit package as a means to identifying and managing chronic conditions of pool enrollees.[47] High-risk pool funds will flow directly from HHS to GHI for plan claims costs in excess of premiums.

Funding. HHS has proposed allocating funds for the program by using a formula almost identical to what is used for CHIP. Specifically, funds will be allotted to states using a combination of factors, including the nonelderly population, the nonelderly uninsured, and geographic cost as a guide. Recognizing that there will be some uncertainties related to enrollment patterns, HHS intends to reallocate allotments after a period of no more than two years based on an assessment of actual enrollment and expenditures in the State pool. HHS estimates that New York could receive $297 million as the Federal subsidy portion of the pool over 42 months.[48] A 2009 Government Accountability Office (GAO) report outlines the national average monthly high-risk pool premium at $600 per month;[49] however, insurance premiums in New York State are considerably higher than national averages.[50]

Enrollment. New York's individual Direct Pay market currently serves 25,000 individuals.[51] The State estimates that its high-risk pool will be able to cover roughly 13,000 additional New Yorkers with pre-existing conditions.

STATE IMPLEMENTATION: CHART 10. Temporary High-Risk Pool	
SUMMARY	Creates a temporary national high-risk pool to provide health coverage to people with pre-existing medical conditions who have been uninsured for six months. This high-risk pool will be implemented quickly and will provide temporary coverage until ACA's broader coverage provisions take effect in January 2014. On January 1, 2014, high-risk pool enrollees will transition into receiving health coverage through the state-based exchanges.
EFFECTIVE DATES	June 21, 2010 (90 days after enactment of the ACA). July 1, 2010 high-risk pool start date.

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47 U.S. Department of Health and Human Services. Solicitation for State Proposals to Operate Qualified High Risk Pools. May 10, 2010. Available at: http://www.hhs.gov/ociio/Documents/state_solicitation.pdf.

48 "Fact Sheet – Temporary High Risk Pools," US Department of Health and Human Services. Available at: http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html. Retrieved 05.03.2010.

49 General Accounting Office. Health Insurance Enrollment, Benefits, Funding and Other Characteristics of State High-Risk Insurance Pools. GAO-09-730R, July 22, 2009. Available at: http://www.gao.gov/products/GAO-09-730R.

50 Agency for Healthcare Research and Quality (HHS/AHRQ), Center for Financing, Access and Cost Trends. 2008 Medical Expenditure Panel.

51 Data provided by the New York State Insurance Department.

STATE IMPLEMENTATION: CHART 10. Temporary High-Risk Pool	
(CONTINUED) FEDERAL FUNDING	ACA appropriates $5 billion of Federal funds for high-risk pool development, available July 1, 2010 through January 1, 2014. The preliminary proposed allocation for New York State for the four-year period is $297 million.[52]
RESPONSIBLE PARTIES	▸ Secretary of HHS will issue regulations that define the minimum benefits and eligibility criteria, among other features of the high-risk pool.
	▸ The New York State Insurance Department is responsible for developing, implementing and managing the high-risk pool through 2014, at which time the agency is required to ensure transition of risk pool enrollees to the State exchange.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ April 30, 2010: New York submitted to HHS a letter of intent to establish a high-risk pool.
	▸ June 25, 2010: New York submitted a letter of designation to HHS identifying GHI as the entity that would contract with the Federal government to administer the high-risk pool in the State.
	▸ July 1, 2010: New York submitted its full high-risk pool application.
	▸ July 1, 2010: New York executed Memorandum of Understanding with GHI and HHS establishing the relationship among the three entities and designating the New York State Insurance Department as the high-risk pool regulator.
	▸ Mid-August 2010: GHI will begin to accept high-risk pool applications.
	▸ October–November 2010: High-risk pool enrollment will commence.
	▸ January 2014: High-risk pool enrollees will be transitioned to the exchange.
	Issues
	▸ Will HHS accept New York's definition of "legally residing" immigrants as including the PRUCOL population? If HHS does not accept the PRUCOL definition, does New York have a constitutional obligation to provide these legally residing immigrants with high-risk pool coverage using State dollars?
	▸ Will HHS accept New York's proposal to have exceptions to the waiting period for involuntary loss of coverage?
	▸ Will HHS accept New York's proposal that beneficiaries be permitted to attest to eligibility criteria including citizenship, pre-existing conditions, and prior coverage?
	▸ How will high-risk pool beneficiaries be migrated to the exchange in 2014, ensuring seamless coverage?
	▸ How will preexisting conditions be defined?

Reinsurance and Risk Adjustment Provisions

ACA creates a series of reinsurance and premium adjustment programs designed to discourage adverse selection and mitigate health plan risk for providing coverage to higher cost enrollees. Two of these programs are temporary, in place from the start of the exchanges in 2014 until the end of 2016: (i) the transitional reinsurance program; and (ii) the Federal risk corridor program. The State program for risk adjustment begins in 2014 and is a permanent program.

[52] Preliminary: Final allotments may increase or decrease by +/- 1%. Data sources: ACS State Population 2008; BLS Wage Data 2008.

TABLE 12. Reinsurance, Risk Corridor, and Risk Adjustment Program*

	TEMPORARY PROGRAMS 2014–2016			PERMANENT RISK ADJUSTMENT PROGRAM DATE TBD - ESTIMATED 2014+	
	Transitional Reinsurance		Federal Risk Corridor		
	Collections from All Plans	Payments All Plans	Payments Adjustments (Positive and Negative)	Collections from Lower Risk Plans	Payments to Higher Risk Plans
TYPES OF PLANS*	Individual Market, Group Market, New Plan	Individual Market	Individual Market, Small Group Market, New Plan	Individual Market, Small Group Market, New Plan	Individual Market, Small Group Market, New Plan
EXCHANGE STATUS OF PLANS	Inside Exchange & Outside Exchange—Qualified Plans *and* Non-Qualified Plans	Inside Exchange	Inside Exchange & Outside Exchange—Qualified Plans *only*	Inside Exchange & Outside Exchange—Qualified Plans *and* Non-Qualified Plans	Inside Exchange & Outside Exchange—Qualified Plans *and* Non-Qualified Plans
FUNDING AND ORGANIZATION	$25 billion		TBD	TBD	TBD
	Not-for-Profit Reinsurance Entity		HHS	Agency or Organization, as Determined by the State	

*Grandfathered health plans and self-insured health plans are excluded from these programs.

Transitional Reinsurance (§ 1341). The transitional reinsurance program is designed to stabilize premiums in the individual market during the first three years of exchange operations when the risk of adverse selection is higher, as individuals are able to purchase health insurance with Federal subsides. The transitional reinsurance program requires the creation of a state reinsurance entity that collects fees from all health insurers based on an amount set by HHS, and makes reinsurance payments to plans in the individual market that have enrolled high-risk individuals. Nationwide, health insurers will be required to make contributions that total $25 billion. The state reinsurance entity will determine the amount of reinsurance that each health insurer will pay based on the payment method selected by the Secretary, which will either be a specified percentage of premiums or claims costs, or a specified per capita amount. Regardless of the method selected, it will be applied to all books of a health insurer's major medical business, both inside and outside the exchange. The Secretary will specify the fixed percentage or the per capita amount using a methodology whereby the total contributions across all states will be $12 billion in 2014, $8 billion in 2015, and $5 billion in 2016.

The state reinsurance entity will make payments to insurers in the individual market that cover high-risk individuals. The payment schedule will be based on a range of high-risk conditions established by the Secretary or an alternative method that will be recommended by the American Academy of Actuaries, and will be designed to encourage the use of care coordination and care management programs.

A state is permitted to establish its own reinsurance organization or join with other states to establish an entity. In addition, a state can choose to contract with one or more nonprofit reinsurance entities to operate the program on its behalf.

Reinsurance for Early Retirees (§ 1102)

On June 29, 2010, HHS announced that it is accepting applications for the Early Retiree Reinsurance Program ("ERRP"), a $5 billion reinsurance program created by the ACA. The ERRP assists employers, including state, county and local governments, in lowering the health insurance costs for early retirees. In order to qualify for the payments, employers must demonstrate that retiree health plans include programs and procedures to generate cost savings related to chronic and high-cost conditions. The ERRP will reimburse employers for medical claims for retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses, and dependents. Employers, including state and local governments and unions, that provide health coverage for early retirees are eligible to apply. HHS will make reinsurance payments for retiree claim costs between $15,000 and $90,000. New York will not have implementation responsibilities with respect to this program, but the State could play an important role in "spreading the word" by launching a communication effort that makes employers aware of the new reinsurance program. Additionally, this program may have significant interest for New York State and county governments as they continue to grapple with retiree health insurance costs.[53]

STATE IMPLEMENTATION: CHART 11.
Transitional Reinsurance Program for Individual Markets in Each State

SUMMARY	Requires each state to establish a transitional reinsurance program as part of the Federal standards, state law, or regulation it adopts to comply with ACA's requirement related to establishing health insurance exchanges and adopting Federal insurance standards.
EFFECTIVE DATE	January 1, 2014 through December 1, 2016.
FEDERAL FUNDING	§ 1005 of HCERA establishes the Health Insurance Reform Implementation Fund within HHS and appropriates $1 billion for Federal administrative expenses.
RESPONSIBLE PARTIES	▸ Secretary of HHS will issue guidance regarding how states will be required to identify individuals with high-risk conditions and the rate methodology that the state reinsurance entity will use to calculate the reinsurance contributions that each health insurer must pay.
	▸ The New York State Insurance Department will establish and possibly operate the State reinsurance entity. The Legislature will enact necessary legislation to establish the program.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Establish a reinsurance entity (or entities) to collect reinsurance contributions from all health plans that participate in the Individual and Small Group market.
	▸ Determine whether to establish or contract with one or more applicable reinsurance entities to carry out the program, or to enter into an agreement with one or more other states to provide for a reinsurance entity to carry out such program in all such states.
	Issues
	▸ New York's Healthy New York Program and the State's Direct Pay market both have State-funded reinsurance programs: how will these programs be aligned and coordinate with the new Federal reinsurance program?

Federal Temporary Program of Risk Corridors (§ 1342). The risk corridor program is a mechanism through which HHS will retroactively shift resources among health plans to account for differences in plans' medical costs during the first three years of exchange operations. Insurers participating in the Individual and Small Group markets that offer a qualified health plan in the exchange must

[53] Applications for Early Retiree Reinsurance Program Now Being Accepted: Affordable Care Act to Provide Financial Relief for Businesses, Unions, State and Local Governments Who Provide Health Insurance for Early Retirees. June 29, 2010. http://www.hhs.gov/news/presshttp://www.hhs.gov/news/press/2010pres/06/20100629a.html.

participate in the Federal risk-corridor program. Like the state reinsurance program, the Federal risk corridor program will help to minimize the impact of adverse selection risk.

The risk corridors are modeled on those applied to regional participating provider organizations in the Medicare Part D program. Specifically, if a plan's "allowable costs" (total amount of costs incurred by the plan in providing covered benefits, minus administrative expenses) are between 97% and 103% of the "target amount" (total annual premium, including subsidies, minus administrative expenses), plans would not receive or make any payment to HHS. If allowable costs are higher than 103% of the target amount for the plan year, the plan would receive a payment from HHS. If allowable costs are lower than 97% of the target amount, the plan would make a payment to HHS.

Unlike the state reinsurance program, which makes payments to plans only in the Individual market, the Federal risk corridor program will make payments to qualified health plans in the Small Group market. The risk corridor program is a Federal initiative that the ACA requires the Secretary to establish and administer. However, HHS may delegate the function to New York's State Insurance Department as the entity responsible for implementing health insurance reform activities. HHS may be inclined to delegate the program in light of data requirements that are consistent and overlap with the data set that the State Insurance Department will obtain as part of the annual premium rate review and MLR analysis.

STATE IMPLEMENTATION: CHART 12. Federal Risk Corridors for Plans in Individual and Small Group Markets	
SUMMARY	Qualified health plans in the Individual and Small Group markets will be subject to positive or negative payment adjustments based on a comparison of a plan's allowable costs and its target amount, which is based on premiums. Plans will receive additional payments from HHS if allowable costs exceed 103% of the target amount. If the allowable costs are less than 97% of the target amount, plans will be required to remit payments to HHS.
EFFECTIVE DATE	January 1, 2014 through December 31, 2016.
FEDERAL FUNDING	§ 1005 of HCERA establishes the Health Insurance Reform Implementation Fund within HHS and appropriates $1 billion for Federal administrative expenses.
RESPONSIBLE PARTIES	▸ Secretary of HHS will develop and provide additional guidance on the program. ▸ HHS may delegate responsibility to State Insurance Department.
STATE IMPLEMENTATION TASKS/ISSUES	**Issues** ▸ Will the State seek authority or be required to implement the risk corridor program in lieu of HHS administration?

Permanent State Program for Risk Adjustment (§ 1343). ACA requires states to establish a risk-adjustment program that applies to health plans in the Small Group and Individual markets both inside and outside of the exchange (the risk-adjustment program does not apply to grandfathered plans or self-insured plans). The risk-adjustment methodology will be developed as part of a consultative process between the states and HHS; HHS is authorized to use criteria and methods similar to the "risk scores" in the Medicare Advantage and Part D programs. The existing Medicare methodology uses an algorithm to create an overall risk profile for various groupings of Medicare beneficiaries. For example, Medicare calculates geographic and health plan-specific risk scores to determine if there are differences in the relative risks of different Medicare populations.

The permanent risk-adjustment program is based on a comparison of the "actuarial risk" of a health plan's enrollees and the average risk profile across all plans and sources of health coverage in a state, except for self-insured plans. If a health plan does not have many high-risk individuals, it will have a lower than average risk score and be defined as a "low actuarial risk plan." In contrast, a "high actuarial risk plan" will reflect higher risk enrollees compared to the risk average. In order to limit the financial risks associated with adverse selection, this new state program will collect fees from lower actuarial risk plans to make additional payments to higher actuarial risk plans.

New York State already has a risk-adjustment program in the Individual and Small Group market pursuant to Insurance Regulation 146. The State will seek to evaluate how the new Federal program aligns or coordinates with Regulation 146.

STATE IMPLEMENTATION: CHART 13. Risk Adjustment	
SUMMARY	Requires each state to establish a permanent program to adjust risk for health plans in the Small Group and Individual markets. Under the program, plans would be classified as low or high actuarial risk. Low actuarial risk plans would be assessed a fee, which the State would use to make additional payments to the high actuarial risk plans because they cover more individuals with high-risk conditions.
EFFECTIVE DATE	**March 23, 2010** (upon enactment). **2014:** CBO estimates include risk-adjustment payments starting in 2014.
FEDERAL FUNDING	§ 1005 of HCERA establishes the Health Insurance Reform Implementation Fund within HHS and appropriates $1 billion for Federal administrative expenses.
RESPONSIBLE PARTIES	▸ Secretary of HHS will issue guidance regarding the risk-adjustment methodology. ▸ The New York State Department of Insurance is responsible for establishing and operating the risk-adjustment program in compliance with forthcoming Federal methodology.
STATE IMPLEMENTATION TASKS/ISSUES	**Issues** ▸ How does the new Federal program fit with New York's existing Insurance Regulation 146 risk adjustment program? Is there a continuing need for this regulation with new Federal requirements?

Premium Rate Review (§§ 1003, 10101[i])

Starting this year, ACA requires that states institute an annual review process for "unreasonable" plan premium rate increases—a standard yet to be defined by the Secretary—and establish state medical reimbursement centers (MRCs) to support premium rate reviews. New York State already provides significant regulatory oversight of plan premium increases, and recently enacted new legislation that will revise and more tightly regulate health insurer premiums. In June 2010, New York State voted to end its current "file and use" process, through which plans file premium increase proposals with the State Insurance Department and implement the rate without "approval" from the State agency. On October 1, 2010, New York State will implement a "prior approval" process for all commercial health insurance premiums that will require insurers to submit premium proposals to the Superintendent of Insurance for review and approval prior to their use in the market. Thus the key question with respect to implementing

this provision of ACA in New York is how the forthcoming Federal process will intersect with New York's new premium approval process.

ACA makes available a total of $250 million to support states' premium rate review efforts and form MRCs that collect, analyze, and organize medical reimbursement information from health insurers. New York could receive between $1 million and $5 million annually for five years based on a Federal formula for state allocation of appropriated funds.[54]

As a condition of receiving Federal funding, New York's MRC will be required to collect from health insurers and provide to HHS information about premium increase trends in the State. The State MRC will also determine plan premium increases deemed "unreasonable" according to new Federal standards, and will make recommendations to the exchange with respect to insurance plans that should be excluded from exchange participation as a result of excessive or unjustified premium increases. The exchange will have the authority to exclude plans with unreasonable premium increases from becoming qualified health plans.

Prior to implementation of "unreasonable" premium increases, health insurers will be required to disclose to HHS, the State MRC, and the public, the justification for the increase. Starting in 2014, the State must conduct ongoing monitoring of premium increases for plans, regardless of whether the health insurance coverage is offered within or outside the exchange. ACA does not prohibit insurers from implementing unreasonable increases, nor does it give states new authority to block unreasonable increases.

ACA places primary responsibility for the development of the premium rate review processes on HHS, though it stipulates that HHS do so in consultation with the states. On April 14, 2010, HHS initiated this process and issued a notice requesting public feedback on current State rate review practices and requirements, and the formula for allocating grant funds.[55]

STATE IMPLEMENTATION: CHART 14. Premium Rate Review	
SUMMARY	The law establishes an annual review process of health insurance premium increases and an "unreasonable" premium increase standard to be defined in forthcoming HHS standards. It also requires health insurers to submit to the Secretary and to state regulators a justification for an unreasonable premium increase prior to the implementation of the increase and to post such justification on their websites.
EFFECTIVE DATE	Begins with fiscal year 2010 and takes effect on March 23, 2010.
FEDERAL FUNDING	▸ Premium Review Grants will be awarded to states during the five-year period beginning with fiscal year 2010 to assist states in carrying out the provision.
	▸ A total of $250 million is available. Each successful state applicant will receive $1 million in the first grant cycle (Cycle I) to be awarded in August 2010.
	▸ The release of the second grant cycle (Cycle II) solicitation will occur after the release of the Federal regulatory rate review guidance in the fourth quarter of calendar year 2010, and grant awards will be made prior to January 1, 2011. The grant formula will be developed by the Secretary, and will be based on the number of health insurance plans and population each state.

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[54] Public Health Service Act §2794(c), as created by ACA §1003.

[55] Federal Register. Premium Review Process; Request for Comments Regarding § 2794 of the Public Health Service Act. Vol. 75, No. 71. Wednesday, April 14, 2010, 75 Fed Reg 19335-19338.

STATE IMPLEMENTATION: CHART 14. Premium Rate Review	
(CONTINUED) **RESPONSIBLE PARTIES**	▸ The Secretary of Health and Human Services will issue additional guidance on the grant award formula, the standards for determining unreasonable premium increases, and premium trend data reporting requirements.
	▸ The New York State Insurance Department will be responsible for establishing the State MRC and ensuring New York's premium rate review process conform to the requirements of the Federal directive.
	▸ New York State will make any changes to ensure that New York Law in this area conforms to ACA.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Establish the State MRC.
	▸ Provide the Secretary with information about trends in health insurance premium increases in State premium rating areas.
	▸ Make recommendations, as appropriate, to the State exchange about whether particular health insurance issuers should be excluded from participation in the exchange based on a pattern or practice of excessive or unjustified premium increases.
	▸ In deciding whether to offer qualified health plans in the Large Group market through an exchange, take into account any excess of premium growth outside of the exchange as compared to the rate of such growth inside the exchange.
	▸ Approve or deny premium increases, as appropriate under State law.
	Issues
	▸ What methodologies will the Federal government employ to define what qualifies as an "unjustified" premium rate increase?
	▸ How will the new HHS standards overlap with or differ from existing New York State standards?
	▸ What data will plans be required to submit to justify rate increases?
	▸ How will new policy mesh with recently enacted legislation to implement requiring "prior approval" of premium rates?
	▸ Will NYSDOH become involved in the premium rate approval process (as it was under the previous iteration of prior approval)?
	▸ How will potential limits on premium increases (especially under a prior approval process) flow through to possibly cause: (a) corresponding limits on health plan annual increases to provider rates; (b) health plans to alter utilization controls or other incentives regarding how care is delivered.
	▸ How will potential limits on premium increases affect health plan commitments or implementation of quality or other initiatives (such as medical homes, electronic health records contributions, etc.)?

Medical Loss Ratios (§§ 1001, 10101)

ACA requires health insurance issuers offering individual or group coverage to annually report to the Secretary the percentages of premiums spent on reimbursement for clinical services, and activities that improve health care quality, a term known in the insurance industry as "medical loss ratios" (MLR). The law also requires insurers to provide enrollee rebates if this spending does not meet minimum standards defined by statute.

With the passage of New York's prior approval law, described above, State statute impose a minimum MLR requirement that is higher than that articulated in the ACA. Implementation of the new Federal requirement will require New York State to cross-walk State MLR thresholds and definitions with new Federal standards—and either align or maintain New York's process, MLR minimum and definition—as permitted by Federal law.

Reporting Requirements: Health insurance issuers offering group or individual coverage are required to submit a report to the Secretary for each plan year concerning the percentage of total premium revenue that the coverage spends on:

- reimbursement for clinical services provided to enrollees;
- activities that improve health care quality; and
- all other non-claims costs, including an explanation of the nature of these costs, and excluding Federal and State taxes, and licensing or regulatory fees.

The Secretary is also directed to make these reports available to the public on the HHS website. The HHS Secretary will also release guidance on the kinds of plan activities that are considered to be quality-related (e.g., whether investment in health information exchange capabilities will count as a quality initiative).

Payment of Rebates to Enrollees: Beginning no later than January 1, 2011, health insurance issuers offering group or individual coverage must, with respect to each plan year, provide an annual rebate to each enrollee if the ratio of: 1) the amount of premium revenue the issuer spends on reimbursement for clinical services provided to enrollees and activities that improve health care quality to 2) the total amount of premium revenue for the plan year (excluding Federal and State taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as defined by ACA[56]) is less than the following percentages, referred to as "the applicable minimum standards:"

- 85% for coverage offered in the Large Group market (or a higher percentage that a given state may have determined by regulation); or
- 80% for coverage offered in the Small Group market or in the Individual market (or a higher percentage that a given state may have determined by regulation), except the Secretary may adjust this percentage for a state if the Secretary determines that the application of the 80% minimum standard may destabilize the individual market in that state).

New York's new prior premium approval law establishes a higher loss ratio minimum for the State's insurers equal to 82% for Small Group and Individual market products. Federal reform also establishes a Large Group minimum MLR, which is not addressed by New York State law, although Large Group premium rates also remain subject to State Insurance Department approval.

[56] Public Laws 111-148&111-152: §§ 1341, 1342, and 1343.

TABLE 13. Medical Loss Ratio Requirements
New York State Standards vs. New ACA Standards

	NEW YORK STATE LAW	AFFORDABLE CARE ACT
Standard	New York State sets MLR standards as part of a prior rate approval process, but allows Insurance Department flexibility to consider unique insurer circumstances.	Federal law sets the MLR standard and requires plans to issue rebates to enrollees if their MLR is below the standard.
Individual	82%	80%
Small Group*	82%	80%
Large Group**	None, but methods insurers use to set premiums for large groups remain subject to State Insurance Department approval.	85%

*Small Group is defined as 50 employees or fewer under New York State law. It is defined as 100 employees or fewer under Federal law with an exception for states to define a Small Group as 50 employees or fewer until January 1, 2016.

**Large Group is defined as 51 employees or more under New York State law. It is defined as 101 employees or more under Federal law with an exception for states to define a Large Group as 51 employees or more until January 1, 2016.

In determining these minimum percentages, states must ensure adequate participation by health insurance issuers, competition in the respective state's health insurance market, and value for consumers so that premiums are used for clinical services and quality improvements. The Secretary may adjust the rates if the establishment of state health insurance exchanges results in volatility of the Individual market.

Beginning on January 1, 2014, the determination of whether the percentage that the coverage spent on clinical services and quality improvement exceeds the applicable minimum standard for the year involved shall be based on the average of the premiums expended on these costs and total premium revenue for each of the previous three years for the plan.

Federal Guidance Required: The National Association of Insurance Commissioners (NAIC) must develop guidelines for standard definitions in accounting for health care costs and calculation methodology for medical loss ratios, and HHS must certify these guidelines by the end of 2010. HHS must develop enforcement rules, and has opted to carry out this responsibility jointly with the U.S. Department of Labor and U.S. Department of Treasury. On April 14, 2010, these three departments jointly issued a request for public feedback to inform the development of final regulations.[57]

[57] 75 Federal Register 19297-19302.

STATE IMPLEMENTATION: CHART 15. Medical Loss Ratio	
SUMMARY	ACA requires health plans to annually report to the Secretary their medical loss ratio (MLR) or proportion of premium dollars spent on reimbursement for clinical services, activities to improve quality, and all other non-claims costs. The law also requires plans to provide a rebate to each enrollee if their MLR is less than 85% of premium revenue for Large Group coverage, and 80% for Individual and Small Group coverage.
EFFECTIVE DATE	**March 23, 2010:** Requirement to report medical loss ratio. **December 31, 2010:** HHS must certify NAIC MLR definition. **January 1, 2011:** Minimum medical loss ratio and enrollee rebate requirements effective.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Implement the State's new prior approval process.
	▸ Determine additional State statute or regulatory changes necessary to align State MLR requirements with new Federal law and forthcoming regulation.
	Issues
	▸ Will New York State adopt Federal definitions of medical care versus administrative services or maintain/modify current State definitions?
	▸ What process will the Secretary define for issuing rebates? Will the State Insurance Department have a role in implementing and/or monitoring the process?
	▸ What is the standard for MLR aggregation? Policy level? Company level? Regulated entity level? Can the State deviate from the aggregation standard established by HHS?
	▸ Will New York maintain its new, higher MLR minimum or align with the lower Federal standard in the ACA?
	▸ How will public policy-oriented expenses (paid as something other than a claim payment to a provider for services rendered to a patient), such as medical home expenses or funding of EHR implementation, be counted under the new requirement?
	▸ Will HHS interpret these as health plan administrative expenses (making it harder to comply with MLR requirements) or cost for activities to improve health care quality?
	▸ How will various New York State-specific taxes be treated with respect to MLR calculation?
	▸ How will broker commissions be treated with respect to MLR calculation?
	▸ Is the new State MRC the entity responsible for the MLR analysis and rebate process?

New Insurance Standards for Health Plans

ACA establishes a number of new requirements for health plans and insurers. Unless otherwise referenced below, these provisions apply to all group health plans and insurers offering Individual and Small Group insurance coverage. Notably, these requirements extend to self-insured plans, which have historically been exempt from the rules and oversight to which other group insurers are subjected. More guidance from the Federal government related

to standards, as well as state enforcement authority, will be necessary to understand the full scope of implementation issues for New York State, but the State will need to harmonize current State requirements with ACA health insurance standards and play an active role in monitoring and enforcing new standards.

The implementation timing of these provisions is aggressive; most provisions must be implemented by September 23, 2010. Health plans in the State are already drafting new, compliant benefit language and grappling with myriad questions regarding the substance of the provisions and how the New York State Insurance Department will harmonize new requirements with existing laws and regulations. New York's insurance market already operates under most of these requirements; in some cases State requirements are more rigorous than those defined by ACA. New York may need to modify current—or develop new—administrative and oversight processes, and pursue regulatory and legislative changes to implement ACA insurance standards.

Lifetime or Annual Limit Prohibition (§§ 1001 [PHSA § 2711], 10101[a], 1251, HCERA § 2301). As of September 23, 2010, plans are prohibited from imposing lifetime limits on the dollar value for "essential health benefits" provided to consumers (categories of services that plans are required to cover) and only permitted to impose "restricted annual limits" on coverage as determined by the Secretary. On June 28, 2010, HHS, the Department of Labor (DOL), and the Treasury jointly issued interim final regulations on this provision, permitting insurers to impose restricted annual limits as low as $750,000 for coverage from September 23, 2010 through September 22, 2011; $1.25 million for coverage from September 23, 2011 through September 22, 2012; and $2 million for coverage from September 23, 2012 through December 31, 2013. As of January 1, 2014, health plans will be prohibited from setting any annual limits on the dollar value of coverage.[58] Plans are not prevented from placing annual or lifetime limits on specific covered benefits that are not essential health benefits as long as such limits are permitted under other applicable Federal or State law. HHS also is allowed to waive the restricted annual limits if the limits would otherwise result in consumers losing significant access to benefits or experiencing a significant increase in premiums.

Rescission Prohibition (§§ 1001 [PHSA § 2712], 1251, HCERA § 2301). After September 23, 2010, ACA prohibits plans from retroactively rescinding, or terminating, coverage of individuals except on grounds of intentional fraud and abuse. On June 28, 2010, HHS, DOL, and the Treasury jointly issued interim final regulations, and indicated that State laws that are more protective of individuals would not be found to be in conflict with, or preempted by, the Federal standard. The regulation also requires plans to provide 30 days advance notice in writing to the affected participant before coverage can be rescinded. Individuals who reach a lifetime limit prior to September 23, 2010, and are otherwise eligible for coverage, will have a special enrollment period to reenroll in coverage.[59] New York already has substantial protections in statute and

[58] Federal Register. Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections. Final Rule and Proposed Rule. Vol. 75, No. 123 / Monday, June 28, 2010. pp. 37188–37241. Available at: http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf.

[59] Ibid.

regulations that eliminate the most frequent causes of rescissions by removing the requirement that individuals report health conditions. Consistent with new Federal requirements, New York Insurance Law does permit revisions related to fraud and abuse. State implementation tasks will include a review of the New York State Insurance Department regulations to determine whether the new law is more restrictive than current New York law, and will reconcile Federal and State definitions of "fraud" as related to rescission cases.

Preventive Health Services (§§ 1001 [PHSA § 2713]). In plan years beginning on or after September 23, 2010, plans are required to provide coverage for a designated set of preventive health services (recommended under existing Federal guidelines, including the U.S. Preventive Services Task Force and the Health Resources and Services Administration (HRSA)) without consumer cost-sharing. Examples of services include immunizations and children's preventive health screenings. HHS must establish an appropriate transition timeframe, at least one year, between the issuance of new preventive care guidelines and expected adoption by health plans. On July 19, 2010, the Departments of Health and Human Services, Labor, and Treasury issued an interim final rule with comment with an effective date of September 17, 2010.[60]

Dependent Coverage Extension (§§ 1001 (PHSA § 2714), 1251, HCERA § 2301). After September 23, 2010, plans are required to extend coverage for children up to age 26, if providing coverage for dependent children.[61] On May 13, 2010, HHS released an interim final rule with comment to define the dependents to whom coverage must be made available.[62] HHS estimates that approximately 8% (2.4 million) of all young adults (ages 19 to 25) will be potentially eligible for coverage, as they are currently uninsured or enrolled in non-group coverage.[63] New York enacted a statute during 2009 that allows an unmarried child to remain on a parent's insurance up to age 29 if he or she is a resident of New York. Additionally, ACA amends the IRS code[64] to give certain favorable tax treatment to coverage for young adults.[65] Specifically, the law amends IRS code to extend the general exclusion from gross income for medical care reimbursement under an employer-provided accident or health plan to any employee's child who has not attained age 27 as of the end of the taxable year. After March 30, 2010, employers may permit employees to begin making pre-tax contributions under a cafeteria plan—a plan that allows employees to choose from a menu of tax-free benefit options—to provide coverage for children under age 27.

60 75 Federal Register 41726.

61 While the provision is not effective until September 23, 2010, several large insurers have indicated they will extend this coverage immediately. "HHS Secretary Kathleen Sebelius on Growing List of Insurers That Will Provide Coverage for Young Adults under Age 26." Press Release, U.S. Department of Health and Human Services, April 20, 2010. http://www.hhs.gov/news/press/2010pres/04/20100420c.html.

62 Federal Register. Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. Vol. 75, No. 92.

63 Federal Register. Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. Vol. 75, No. 92/Thursday, May 13, 2010. May 13, 2010. pp.27122-27140 Available at: http://edocket.access.gpo.gov/2010/pdf/2010-11391.pdf.

64 Public Laws 111-148&111-152: §1004(d)(1)).

65 April 27, 2010 IRS Notice 2010-38 on the tax treatment provision notes that the dependent coverage provision does not parallel the tax treatment provision in some respects.

TABLE 14. Dependent Coverage
(Current New York State Law vs. New ACA Requirements)

	NEW YORK STATE LAW	AFFORDABLE CARE ACT
Age	Up to and including age 29.	Up to and including age 25.
Residency	Dependent must reside in New York State or in the geographic service area, if any, of the insurer's network.	Dependent not required to reside in the State.
Employer Sponsored Coverage (ESC)	Must not have other employer-sponsored coverage available.	Grandfathered plans can exclude a dependent if he/she has access to employer-sponsored coverage.
Other Requirements	▸ Only unmarried qualify.	▸ Married and unmarried qualify.
	▸ Need not live with parent.	▸ Need not live with parent.
	▸ Need not be financially dependent upon the parent.	▸ Need not be financially dependent upon the parent.
	▸ No requirement to be a student.	▸ No requirement to be a student.
	▸ Not be covered by Medicare.	▸ Coverage does not extend to spouse or dependent's children.
Type of Coverage	**Make available coverage:** Every insurer that issues a policy or contract that provides coverage for dependent children must make available and, if requested by the policy or contract holder or remitting agent, extend coverage to qualifying young adults through age 29 as dependents under family coverage. The "extra" cost of this coverage is spread throughout the entire group.	Insurers must allow a dependent to remain in family coverage up to age 26. The "extra" cost of this coverage is spread throughout the entire group. Young adults must be offered the same benefit package as similar individuals who were already covered as dependents.
	Mandatory coverage: Dependent independently purchases coverage through the parent's group policy or contract. Dependent does not remain in family coverage.	
Applicable Plans	HMOs, not-for-profit insurers, and commercial insurers offering employer sponsored coverage.	Group health plans, health insurers offering group and individual coverage.

Prohibition on Discrimination in Favor of Highly Compensated Individuals (§ 1001 [PHSA § 2716], 10101[d]). As of September 23, 2010, insured group health plans must comply with the nondiscrimination requirements for self-funded plans (IRC Sec. 105(h)(2)), including rules that the plan does not discriminate in favor of highly compensated individuals with regard to eligibility or benefits provided under the plan. The new prohibitions against discrimination in fully insured plans prevent employers from providing executives and key employees with tax-free reimbursements for out-of-pocket medical, dental, and vision expenses under plans that are not "grandfathered." The penalty for offering a discriminatory insured medical plan appears to be a $100-per-day excise tax.

Pre-Existing Condition Exclusions Prohibition or Other Discrimination Based on Health Status (§ 1201[2][a] [PHSA §§ 2704, 2705], 10103[e], HCERA § 2301). As of September 23, 2010, health insurers are prohibited from withholding coverage for children under the age of 19 due to a pre-existing condition. In 2014, the prohibition on pre-existing condition exclusions will be extended to all individuals. On June 28, 2010, HHS, DOL and the Treasury jointly issued interim final regulations on this provision. The regulation defines a pre-existing condition exclusion as a limit or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of a consumer's coverage (or the date of denial of coverage). The regulation applies this definition regardless of whether a consumer has received any medical advice, diagnosis, care or treatment.[66] ACA further specifies seven health status-related factors (such as claims experience, genetic information, or disability) that cannot be used in determining eligibility for coverage. HHS has the discretion to specify additional health status factors. New York State is a guaranteed issue State—no one is rejected from purchasing coverage because he or she has a pre-existing condition and/or any prior medical history or risk factors. However, New York does permit a waiting period of up to 12 months (after coverage begins) for coverage of those pre-existing conditions that were actually treated or for which an individual consulted a physician in the six months prior to the commencement of coverage (coverage for other medical problems begins immediately).

Quality Reporting (§§ 1001 [PHSA § 2717], 10101[e]). ACA requires plans to submit annual reports to HHS on their activities and reimbursement structures related to quality improvement, hospital readmission prevention, patient safety, and wellness and health promotion. HHS must develop reporting requirements and issue regulations on the criteria for evaluating whether reimbursement structures fulfill the specified goals. The deadline for HHS to promulgate regulations is March 23, 2012.

[66] Federal Register. Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections. Final Rule and Proposed Rule. Vol. 75, No. 123 / Monday, June 28, 2010. pp. 37188–37241. Available at: http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf.

Appeals Process (§§ 1001, 10101 [PHSA § 2719], 10101[g]). After September 23, 2010, ACA requires plans to implement internal claims appeals and external review processes. For internal claims appeals, health plans must initially comply with existing rules and then with any additional requirements that may be specified by the U.S. Department of Labor and HHS. For external review processes, health plans must comply with either State standards that meet minimum NAIC Uniform External Review Model Act consumer protections or, in the absence of State standards or for plans not regulated by the State, standards to be established through HHS guidance. New York already has both internal and external review requirements and may need to harmonize requirements with the Federal guidance. On July 23, 2010, the Departments of Health and Human Services, Labor, and Treasury issued an interim final rule with comment with an effective date of September 21, 2010.[67]

Guaranteed Issue (§ 1201 [PHSA §§ 2702, 2703]). Effective January 1, 2014, health insurers must sell insurance policies to interested individuals and employers ("guaranteed issue") and continue to provide these policies ("guaranteed renewability") as long as they remain interested. Health plans may restrict enrollment timeframes by establishing open enrollment periods, but must also establish special enrollment periods that would allow interested individuals to join or modify their coverage due to a "qualifying event" addressed in existing law (e.g., change in marital status or loss of employment). New York already has guaranteed issue, and open enrollment for individuals and small groups is continuous throughout the year.

Waiting Periods (§ 1201 [PHSA § 2708], § 1251, HCERA § 2301). Effective January 1, 2014, health plans are prohibited from applying waiting periods for health coverage that exceed 90 days. This provision applies to all group health plans.

Coverage of Emergency Services (§ 2719A). Effective September 23, 2010, health insurance issuers in the Individual and Small Group markets that cover emergency services provided in a hospital are required to cover those services:

- without the need for any prior authorization determination;
- regardless of whether the hospital or physician providing the services is a participating provider in the plan's network; and
- without imposing any authorization requirements or coverage limitations when services are provided by out-of-network providers that are more restrictive than the requirements of in-network providers.

Additionally, the ACA requires that if emergency services are provided out of network, the consumer cost-sharing requirement (co-payment amount or coinsurance rate) is the same as would apply if services were provided in-network. On June 28, 2010, HHS, DOL, and the Treasury jointly issued interim final regulations providing additional guidance on this provision.

[67] 75 Federal Register 43330.

Access to Pediatric Care (§ 2719A). Health insurance issuers that require beneficiaries to select a primary care provider must permit families to designate a provider who specializes in pediatrics as a child's primary care provider to the extent that pediatric specialists participate in the plan network.

Patient Access to Obstetrical and Gynecological Care (§ 2719A). Health insurance plans must provide female beneficiaries with "direct access" to obstetrical and gynecological (OB/GYN) care provided by participating providers. Specifically, plans may not require prior authorization or referrals for OB/GYN care. Providers must in turn agree to adhere to the health plans policies and procedures with respect to referrals and obtaining prior authorization for services.

Standardized Format for Benefits and Coverage Summaries (§ 2715, § 1251, HCERA § 2301). ACA requires that plans provide standard consumer oriented information using a standardized format in areas including benefits summaries, coverage information, quality, and complaints and appeals processes. HHS must develop a standardized format in consultation with NAIC and a stakeholder workgroup and issue the standards, which will include requirements around presentation and content, by March 23, 2011. HHS must also promulgate regulations providing standards for common health insurance and medical terms.

Community Rating (§ 2701). The ACA requires that health insurance issuers in the Individual or Small Group market employ modified community rating in establishing premium rates so that rates vary only by:

- whether the coverage is for an individual or family;
- rating area;
- age (3:1 variation for adults); and
- tobacco use (1.5:1 variation).

The law also requires states to establish one or more state rating areas for purposes of applying modified community rating. New York State already requires community rating in its Individual and Small Group markets. However, the State employs a "pure" community rating mechanism, meaning that insurers are not permitted to use age or gender to vary premium rates. New York will have to decide whether and how it will adjust its community rating rules to align with new Federal rules.

Grandfathered Health Plans (§ 1251)

ACA "grandfathers" existing individual and group plans, exempting them from several consumer protections and new benefit standards. Health plans and insurance coverage in effect as of March 23, 2010 are grandfathered and will be considered "qualified coverage" that meets the mandate for individual coverage that begins in January 2014. The grandfather rule also allows family members and new employees to subsequently join an existing employer plan without ending the grandfather protection. The grandfather provisions were included in the reform package to provide a transition period for health insurers and employers. In June 2010, HHS released a final interim rule further clarifying grandfathered status.[68]

ACA PROVISIONS THAT APPLY TO GRANDFATHERED PLANS:

- Extension of dependent coverage through age 26.
- Bans on pre-existing condition exclusions for group health plans and group health insurance coverage only.
- Prohibition on lifetime dollar limits.
- Prohibition on annual dollar limits for group health plans and group health insurance coverage only.
- Rescission prohibitions.
- Development and use of uniform explanation of coverage materials and standard definitions.
- In addition, grandfathered health plans will be blocked from retroactively canceling coverage after a policyholder gets sick.

ACA PROVISIONS THAT DO NOT APPLY TO GRANDFATHERED PLANS:

- Bans on pre-existing conditions for individual health insurance coverage only.
- Provision that prohibits health plans from charging co-payments and other cost sharing for certain preventive health services, such as immunizations and cancer screenings.
- Requirement that health plans cover certain treatments associated with clinical trials.
- Prohibition on annual dollar limits for individual health insurance coverage only.
- Annual out-of-pocket cost limits.
- Limits on premium variations based on age and tobacco use.
- Waiting period limits.
- Non-discrimination provision.
- Premium risk adjustment.

Any insurance product sold to new individuals or entities after March 23, 2010 will not be grandfathered even if the product was offered before March 23rd and has grandfathered status for existing employers and beneficiaries. To maintain grandfathered status, a plan must disclose to beneficiaries that it is a grandfathered plan and provide contact information for questions and complaints. The plan must also maintain records documenting the terms of the plan or health insurance coverage that were in effect on March 23, 2010. Certain changes to plan benefit structures may trigger loss of grandfather status. The interim final rule defines the specific changes that will cause cessation of grandfather status including: the elimination or substantial reduction of benefits, increase in coinsurance, a significant increase in cost-sharing requirements or deductibles, a significant decrease in employer contributions for coverage, an addition to or tightening of existing annual limits, and a change in insurance carrier.

[68] Federal Register. Group Health Plans and Health Insurance Coverage Rules Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule. Vol. 75, No. 116 / Thursday, June 17, 2010. pp. 34571-34572. Available at: http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf.

Access to Care for Insured and Uninsured New Yorkers

While the coverage expansions under ACA will enhance access to care generally for those currently uninsured, it is also likely to generate increased demand for medical services across the State, heightening the need for expanded and improved primary care. These demands will be particularly pronounced among those enrolled in Medicaid and those living in medically underserved areas, and will perhaps be most severe for the remaining uninsured.

Despite significant expansions in public and private coverage options, not all New Yorkers will have access to affordable health insurance when ACA is fully implemented in 2014. Undocumented immigrants are wholly left behind under Federal reform, are ineligible to purchase coverage at full cost through the exchange, and are excluded from public health insurance coverage.

New York—although required to provide Medicaid to otherwise eligible immigrants who are in the country legally, including those residing in the U.S. for less than five years—does not receive any Federal financial support for health coverage for most such lawful immigrants.[69] Federal health care reform failed to correct, and may potentially exacerbate, the impact of this inequity. While documented immigrants may purchase coverage through the exchange and will be eligible for subsidies, this option is likely to be unaffordable for the lowest income immigrants. Some New Yorkers may qualify for affordability exemptions from the health insurance mandate; others may choose to pay penalties rather than purchase coverage. Families with incomes so low that they are not required to pay taxes—while likely eligible for public coverage—are not subject to the individual coverage penalties, and despite increased outreach, may not choose to enroll.

In New York State, nearly 400,000 undocumented residents will remain uninsured after implementation of health care reform coverage expansions and the exchange in 2014. In addition, those New Yorkers who are eligible for Medicaid or subsidies and choose to remain uninsured, and/or pay penalties, could number as many as 1.4 million individuals (see Table 1).

Recognizing the challenges faced by states in ensuring access to health care services for newly insured and uninsured individuals, the ACA offers targeted provisions to enhance access by: increasing physician primary care fees in Medicaid and Medicare, and substantially investing

Who Remains Uninsured?

In 2014, the following New Yorkers will remain among the ranks of the uninsured:

- Undocumented adult immigrants.
- Low- and moderate-income New Yorkers who are ineligible for public coverage and exempt from the requirement to purchase coverage through the Exchange.
- Those who choose not to obtain coverage despite having to pay penalties.
- Those who are Medicaid eligible, but fail to enroll and remain uninsured.

[69] *Aliessa v Novello*, 96 NY2d 418 [2001]; Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law 111-3).

in community- and school-based health centers. ACA also provides funding to grow and strengthen the health care workforce to respond to increased demand for services. At the same time, ACA seeks to reapportion funding for safety net hospitals, reduce overall funding levels in anticipation of reduced numbers of uninsured, and target remaining funds to hospitals and states with the highest need.

ENHANCEMENTS FOR MEDICAID PAYMENTS FOR PRIMARY CARE (§ 1202)

In order to increase access to primary care for Medicaid beneficiaries, ACA mandates that states pay 100% of the Medicare payment rate as reimbursement for primary care services provided by physicians participating in Medicaid during calendar years 2013 and 2014. The law provides 100% Federal matching dollars for the difference between a state's current reimbursement level and the Medicare reimbursement amount during these two years. Primary care services are defined as those provided by physicians with a primary specialty designation of family medicine, general internal, medicine or pediatric medicine in the Evaluation and Management (E&M) category under the Healthcare Common Procedure Coding System used by Medicare, as well as services related to immunization administration for vaccines and toxoids. Medicaid managed care plans must make payments to physicians consistent with the new minimum payment rates.

Currently, New York's Medicaid fees for primary care services range from 57% to 92% of Medicare fee levels depending on the care delivery setting, and whether the service is reimbursed by the Medicaid fee-for-service program or Medicaid managed care plans. There are a host of issues in determining how to apply the mandate and additional funding to physician fees in New York State, including how to treat the add-ons New York currently offers for physicians practicing in underserved areas, for weekend and evening hours, and for meeting medical home standards. Moreover, while uncertainty about the expected duration of increased payments persists, it is unclear whether enhanced reimbursement will increase the number of primary care physicians serving Medicaid patients, as was intended by the law.

STATE IMPLEMENTATION: CHART 16. Medicaid Primary Care Reimbursement	
SUMMARY	Requires states to pay physicians for primary care services furnished in 2013 and 2014 at a rate that is no less than 100% of the Medicare payment rate (if greater, the Medicare payment rate in effect in 2009 should be used). Rate increase is limited to physicians with a primary specialty designation of family, general internal, or pediatric medicine.
EFFECTIVE DATE	January 1, 2013 through December 31, 2014.
FEDERAL FUNDING	Provides for 100% Federal funding for services provided for the difference between (i) the payment rates required under this provision; and (ii) the level of payment in effect in the State Medicaid program on July 1, 2009. Regular Federal matching applies for any payment amounts above the minimum requirement.
RESPONSIBLE PARTIES	Secretary of HHS. The New York State Department of Health.

continued on next page ▶

STATE IMPLEMENTATION: CHART 16. Medicaid Primary Care Reimbursement	
(CONTINUED) STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Revise Medicaid fee schedules for relevant E&M codes.
	▸ Determine current State Medicaid rates vs. new Federal enhancement to determine dollars eligible for 100% FMAP.
	▸ Define the universe of physicians who will receive the enhancement.
	▸ Devise a plan and implement the new reimbursement mandate.
	Issues
	▸ Will the enhancement apply to both of New York's primary care fee schedules—office-based and institutional providers?
	▸ The bill does not address what happens after 2014. Will the Federal match be extended? If the Federal match program is not extended, how would New York State fund the rate increase after the Federal funding expires?
	▸ How does the program interface with other State and Federal demonstration projects including medical home shared savings programs and the patient-centered medical home initiative?
	▸ How will the new primary care enhancement be implemented across New York's Medicaid managed care health plans, many of which pay primary care capitation?
	▸ How will the State's large Medicaid managed care program change its analysis of current Medicaid rates for primary care services in determining enhanced FMAP?

REDUCED FUNDING FOR UNINSURED CARE IN PUBLIC AND VOLUNTARY SAFETY NET HOSPITALS

In response to the anticipated decrease in demand among uninsured individuals in light of expanding coverage under reform, ACA reduces resources available to safety net hospitals available through both Medicaid and Medicare Disproportionate Share Hospital funding. ACA also establishes new requirements for nonprofit hospitals' financial assistance policies for uninsured patients, and imposes an excise tax on organizations failing to comply with these requirements.

TABLE 15. Aggregate Reductions in Medicaid Disproportionate Share Hospital Payments[70]

FISCAL YEAR	REDUCTION
2014	$500,000,000
2015	$600,000,000
2016	$600,000,000
2017	$1,800,000,000
2018	$5,000,000,000
2019	$5,600,000,000
2020	$4,000,000,000

[70] Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). March 20, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

Medicaid Disproportionate Share Hospital Funding (§ 1203)

Medicaid Disproportionate Share Hospital (DSH) payments provide financial support to hospitals with large numbers of Medicaid and uninsured patients. Federal Medicaid DSH funding in 2009 totaled more than $11 billion, including increased funding under ARRA, of which New York received $1.6 billion.[71] ACA makes significant reductions to DSH allotments from 2014 to 2020. Overall Federal allotment levels are reduced by $500 million in 2014 and the level of reductions increase annually to a $5.6 billion reduction in 2019. The HHS Secretary will develop the DSH allotment reduction methodology to apply funding reductions to states. The methodology will be structured to ensure that states using DSH funding appropriately are able to retain such funding. Specifically, the methodology will:

- apply the largest reductions to states that (i) have the lowest uninsured rates (based on Census data), (ii) have the lowest levels of uncompensated care (excluding bad debts), and (iii) do not target DSH payments to hospitals with high volumes of Medicaid inpatient care; and
- apply lesser reductions to low-DSH states, defined as those with Medicaid DSH expenditures at 0–3% of total state Medicaid spending.[72]

The methodology will also take into account the extent to which DSH payments are included in budget neutrality calculations for State waivers.

Given the important role Medicaid DSH plays in supporting both public and private safety net hospitals, New York will need to monitor and intervene as HHS develops the reduction methodology to ensure that New York is not disadvantaged. To make the strongest case possible, New York will want to be certain that it has credible data on the volume and cost of services rendered to uninsured patients, as well as Medicaid patients. Once HHS finalizes the DSH reduction methodology, New York will have to decide how to apply the State dollars no longer eligible for Federal matching dollars as a DSH payment. The State could determine to retain the dollars as budget savings. In addition, New York may want to revise its allocation formula to ensure that hospitals continuing to see large numbers of uninsured patients receive additional financial support. Finally, to the extent that New York loses Federal DSH dollars, it may want to shift state DSH dollars to support Medicaid rates and draw down Federal matching dollars.

In recent years, State policy changes have been made to New York's methodology for distributing indigent care funds that permit more transparency and accountability in their distribution. It will be important to understand how such policies will impact New York's ability to illustrate how funds are spent and make the strongest case possible for retaining the maximum share of Federal allotment.

[71] National Health Policy Forum. The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments. National Health Policy Forum. June 15, 2009. Available at: http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.

[72] Ibid.

Medicare Disproportionate Share Hospital Funding (§ 1104)

Medicare DSH payments to hospitals also will be reduced starting in 2014, with total projected reductions of $22 billion over 10 years.[73] ACA outlines a new formula for determining Medicare DSH funding distribution which starts with a 75% reduction in payments for each hospital. The new baseline is defined in ACA as an "empirically justified amount," and was originally recommended by the Medicare Payment Advisory Commission in its March 2007 Report to Congress, which analyzed the cost and level of uncompensated care provided by all hospitals. The baseline will be supplemented for each hospital by an additional payment, the amount of which is derived from a complex three-part formula considering: **(1)** the change in the DSH payment; **(2)** the change in the number of uninsured based on the Census; and **(3)** the amount of uncompensated care provided by the hospital compared with the average level provided by all hospitals. The HHS Secretary has broad authority over defining DSH payments and there is no judicial review of the key decisions, which impact the distribution of DSH payments above the 25% baseline.

As with the Medicaid DSH reduction, New York State will want to collaborate with HHS in decisions regarding Medicare DSH to ensure that New York is treated fairly. Moreover, decisions on Medicare DSH funding will inform the State's approach to allocating Medicaid DSH, as both payment streams are vital to the support of New York's safety net hospitals.

Medicaid Global Payment System Demonstration Project (§ 2705)

ACA establishes the Medicaid Global Payment System demonstration project in coordination with the Center for Medicare and Medicaid Innovation (CMI), a newly established office within CMS. The demonstration is authorized for fiscal years 2010 through 2012; up to five states will be selected by the Secretary to participate through a yet to be determined process. Under the demonstration, states would pay participating large safety net hospital systems or networks under a global capitated payment model, as opposed to a fee-for-service model. For purposes of this demonstration project, the term ''eligible safety net hospital system or network'' is defined as a large, safety net hospital system or network (as defined by the Secretary) that operates within a state selected by the HHS Secretary to participate in the project. The CMI is charged with testing and evaluating each project to determine changes in health care quality outcomes and spending by the participating safety net institution. Federal funds are authorized to be appropriated; "such sums as are necessary" to implement the demonstration. Budget neutrality requirements as outlined under § 1115A(b)(3), generally a standard feature of Medicaid waiver demonstration projects, are lifted. New York has the option of collaborating with safety net hospital(s) in the State to apply for participation in this demonstration. A significant issue for the State and providers will be how this demonstration interfaces with and/or co-exists with the State's large Medicaid managed care program.

[73] Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). March 20, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf. See also Congressional Research Service. Medicare Provisions in ACA (P.L. 111-148). April 21, 2010. Available at: http://www.aamc.org/reform/summary/PPACMedicareProvision042810.pdf.

Additional Requirements for Charitable Hospitals (§ 9007)

Finally, ACA establishes new requirements for 501(c)(3) hospitals related to the conduct of community needs assessments and establishment of a financial assistance policy for uninsured patients, and imposes an excise tax on organizations failing to comply with these requirements. The new requirements for 501(c)(3) hospitals apply separately to each hospital facility within an organization. The new rules take effect in the taxable year after the date of enactment of the ACA, with the exception of the community needs assessment requirement, which takes effect two years after date of enactment. Charitable hospitals must:

- conduct a community needs assessment at least once every three years and adopt an implementation strategy to meet the needs identified through the assessment;
- implement and publicize a financial assistance policy that includes, among other requirements, information regarding eligibility for free or discounted care and the basis for calculating amounts charged to patients;
- limit charges for medically necessary or emergency care for patients that qualify for financial assistance to no more than the lowest amounts charged to insured patients for such care, and prohibit the use of gross charges; and,
- refrain from engaging in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for financial assistance.

ACA requires hospitals to submit to the Internal Revenue Service (IRS) an assessment of how well community needs are being met, including audited financial statements, and imposes an excise tax of up to $50,000 on organizations failing to comply with these requirements.

New York already requires hospitals to perform community needs assessments and to have financial assistance policies that comply with specific standards in State law.[74] It is, as yet, unclear how the Federal requirements will compare to these existing State mandates.

COMMUNITY HEALTH CENTERS (§ 10503, HCERA § 2303)

Today, 50 federally qualified health centers (FQHCs) operate in New York State and serve 1.3 million patients through 508 delivery sites.[75] Federal support for these community health centers is significantly bolstered through the establishment of a Community Health Center Fund in ACA; between FY 2011 and 2015, the law makes available $9.5 billion to enhance operating capacity and $1.5 billion for construction and renovation. Operations funds may be used for base grant adjustments, expanded medical capacity and service expansions (oral, behavioral, and pharmacy), new health centers and new sites for existing health centers, and enabling services. Construction and renovation funds can be used for expanding and improving existing facilities, and constructing new buildings. An additional $1.5 billion is designated for the National Health Services Corps (NHSC), which is charged with recruiting and placing health care professionals in health professional shortage areas.

The new funds have been estimated to enable community health centers to add approximately 15,000 providers and serve nearly 20 million new patients, nearly double the number currently

[74] New York State Public Health Law 2803-L.

[75] National Association for Community Health Centers. Key Health Center Data by State, 2008. Available at: http://www.nachc.com/client/documents/state_X_key_facts_2008.pdf.

being served, by 2015.[76] Additional information regarding the parameters and availability of this new funding is expected from Health Resources and Services Administration, which will have discretion in directing these funds. However, the amount of funding coming to New York will be determined in part by a competitive bidding process. The first round of applications to apply for this funding may be out as soon as early summer 2010, and the first awards can be made as soon as the start of the 2011 fiscal year (October 1, 2010).[77, 78]

Other provisions, while not specifically targeted to the uninsured, will further strengthen the ability of community health centers to continue to serve a safety net function.

FQHC Medicaid Reimbursement Rates in the Exchange. ACA requires that health plans operating within the exchange pay FQHCs at least the Medicaid reimbursement amount for any service or item covered by a plan operating in the exchange. Because Federal law mandates a facility-specific, cost-based payment methodology for Medicaid reimbursement of FQHCs designed to ensure that health centers are paid for their costs, this rate is often higher than what health centers would be able to negotiate in the private market (§ 1302(g)).

TABLE 16. Community Health Centers and the National Health Service Corps Fund

YEAR	COMMUNITY HEALTH CENTER 330 FUNDS[79]	NATIONAL HEALTH SERVICE CORPS FUND[80]	CONSTRUCTION AND RENOVATION
2011	$1,000,000,000	$290,000,000	
2012	$1,200,000,000	$295,000,000	
2013	$1,500,000,000	$300,000,000	$1,500,000,000
2014	$2,200,000,000	$305,000,000	
2015	$3,600,000,000	$310,000,000	

Medicare. ACA expands the number of Medicare-covered preventive services at FQHCs effective January 1, 2011, and requires that the Secretary design and implement a prospective payment system (PPS) for Medicare payments to FQHCs effective October 1, 2014. The PPS must include: **1)** a process for appropriately describing the services provided by FQHCs; **2)** payment rates for specific payment codes based on the description of these services; and **3)** the ability to take into account the type, intensity, and duration of these services. The system can include adjustments to the PPS, including geographic adjustments, as determined by the Secretary. While ACA requires budget neutrality, it is based on 100% of estimated reasonable costs determined without the application of a per-visit payment limit or productivity screen, and allows for annual updates using either the Medical Economic Index (MEI) or, beginning in the second year of implementation, the FQHC market basket, if available (§ 10501).

76 Eli Y. Adashi, M.D., H. Jack Geiger, M.D., and Michael D. Fine, M.D, .Health Care Reform and Primary Care — The Growing Importance of the Community Health Center. Available at: http://healthcarereform.nejm.org/?p=3377.

77 hc.com/healthreform.cfm.

78 Fact Sheet: Health Centers and Health Care Reform – National Health Service Corps. Available at: http://www.nachc.com/healthreform.cfm.

79 The CHC Fund is in addition to existing discretionary funding, which was $2.19 billion in FY 2010.

80 This increased funding for the National Health Service Corps is in addition to existing discretionary funding, which was $142 million in FY 2010.

Family Nurse Practitioners. ACA requires that the Secretary establish demonstration programs to employ and provide one year of training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in FQHCs and nurse-managed health clinics. ACA authorizes appropriation amounts as are necessary for each of FYs 2011–2014 to award grants. Grants cannot exceed $600,000 per year, though grant recipients can carry over grant funds from one fiscal year to another (§ 10501).

STATE IMPLEMENTATION: CHART 17. Community Health Centers and the National Health Service Corps Fund	
SUMMARY	Establishes a Community Health Center Trust Fund (CHC Fund) to provide additional funding to community health centers and the National Health Service Corps Fund.
EFFECTIVE DATE	Fiscal Year 2011.
FEDERAL FUNDING	▸ $9.5 billion increased funding to community health centers
	▸ $1.5 billion increased funding to the National Health Services Corps
	▸ $1.5 billion in funds for construction and renovation
RESPONSIBLE PARTIES	Health Resources and Services Administration (HRSA) will issue guidance regarding the parameters and availability of new funds, including an RFA expected during summer 2010.
STATE IMPLEMENTATION TASKS/ISSUES	While there is no specific State implementation role with respect to maximizing funding to New York FQHCs under these provisions, there are significant implementation tasks for FQHCs and their State and national associations including:
	▸ Developing a statewide plan to identify regional priorities for expansions of existing FQHCs or seeding new FQHCs.
	▸ Identifying opportunities for partnership between FQHCs and existing providers.
	▸ Coordinating and leveraging New York FQHC applications in the competitive bidding process for CHC Fund awards.
	▸ Identifying and implementing strategies to manage growth.

SCHOOL-BASED HEALTH CENTERS (§ 4101)

New York currently has 222 school-based health centers (SBHCs), serving nearly 150,000 children and youth in the State.[81] ACA creates new programs to support the establishment and operation of SBHCs, providing $50 million for each of FYs 2011–2013. These funds may be used only for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility); equipment or similar expenditures as specified by the HHS Secretary (i.e., the funds may not be used for expenditures for personnel or to provide health services). Only SBHCs or sponsoring facilities of SBHCs are eligible to apply for grant funds. ACA also authorizes amounts to be appropriated as may be necessary for each of FYs 2010–2014 for grants for the SBHC operation. These funds may be used for acquiring and leasing equipment, providing training, the management and operation of health center programs, and the payment of salaries for personnel. Grants may also be awarded to pay for the costs associated with expanding

[81] New York State Department of Health. School-Based Health Center Fact Sheet. April 2010.

and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings. While the statute imposes a 20% matching requirement, this may be waived if it would impose a serious hardship.

ACA also expands oral health care prevention activities within SBHCs by making mandatory a previously discretionary school-based dental sealant program and requiring the HHS Secretary to award grants to each of the 50 states and territories, and to Native American organizations, for oral health care prevention activities. States must apply for and administer funds under this initiative (§ 4102).

CHART 18. School-Based Health Centers	
SUMMARY	Establishes new programs to support the establishment and operation of school-based health centers (SBHCs).
EFFECTIVE DATE	Fiscal Year 2010
FEDERAL FUNDING	▸ $150 million for establishment of SBHCs
	▸ Authorizes appropriation amounts as are necessary for each of FYs 2010–2014 for operation of SBHCs
RESPONSIBLE PARTIES	HHS, SBHCs, and sponsoring facilities of SBHCs
STATE IMPLEMENTATION TASKS/ISSUES	While there is no specific State implementation role with respect to maximizing funding to New York SBHCs under the rest of these provisions, there are significant implementation tasks for SBHCs and their State and national associations including:
	▸ Apply for funds for the newly mandated school-based dental sealant program.
	▸ Develop a statewide plan to identify regional priorities for expansions of existing SBHCs or seeding new SBHCs.
	▸ Identify opportunities for partnership between SBHCs and existing providers.
	▸ Coordinate and leverage New York SBHC applications in the competitive bidding process for SBHC grants.

PRIMARY CARE EXTENSION CENTER PROGRAM (§ 5405)

ACA establishes a Primary Care Extension Program, to be administered by the Agency for Healthcare Research and Quality (AHRQ), to provide support and assistance to primary care providers. The centers will work to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based therapies and techniques in order to enable providers to incorporate such lessons into their practices. To implement the provision, the HHS Secretary must award competitive grants to states for the establishment of "State Hubs" and Local Primary Care Extension Agencies. ACA authorizes $120 million per year for fiscal years 2011 and 2012, and such sums as necessary in fiscal years 2013 and 2014, for the establishment of the Primary Care Extension Center Program.

In New York, State Hubs must consist of at least the State Department of Health and the departments of one or more health profession schools that train providers in primary care. State Hubs may also include other relevant State entities and will be responsible for:

- submitting to the Secretary of HHS a plan to coordinate functions with quality improvement organizations and area health education centers;
- contracting with and administering grant funds to county- or local-level Primary Care Extension Agencies; and
- organizing statewide or multi-state networks of local-level Primary Care Extension Agencies through which to share and disseminate information and best practices.

Local Primary Care Extension Agencies will enter into contracts administered by the State Hub and will be responsible for:

- assisting primary care providers with implementing patient-centered medical homes;
- developing and supporting primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assessing implementation of practice improvement, and sharing best practices;
- participating in a national network of Primary Care Extension Hubs; and
- developing a plan for financial sustainability involving State, local, and private contributions that account for the reduction in Federal funds expected after an initial six-year period of program establishment, infrastructure development, and planning.

STATE IMPLEMENTATION: CHART 19. Primary Care Extension Center Program	
SUMMARY	The ACA establishes the Primary Care Extension Center Program, a competitive grant program that will award funding to states for the establishment of "State Hubs" and Local Primary Care Extension Agencies that provide support and technical assistance to primary care providers.
EFFECTIVE DATE	Fiscal Year 2011
FEDERAL FUNDING	▸ $120 million per year for fiscal years 2011 and 2012
	▸ Such sums as necessary in fiscal years 2013 and 2014 for the establishment of the Primary Care Extension Center Program.
RESPONSIBLE PARTIES	▸ Agency for Healthcare Research and Quality will administer the program and implement a competitive grant process for states.
	▸ The New York State Department of Health has the option of applying for grant funding to establish a "State Hub" that will contract with and administer grant funds to county-or local-level Primary Care Extension Agencies.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks**
	▸ Apply to AHRQ for grant funding to establish State Hubs.
	▸ Submit to HHS a plan to coordinate with local and State quality improvement programs.
	▸ Organize a statewide or multi-state network of Primary Care Extension Centers.
	▸ Contract with and administer grants to Primary Care Extension Centers.
	Issues
	▸ How will these hubs be maintained once Federal grant funds expire?

WORKFORCE

With as many as 1.2 million New Yorkers becoming newly insured as a result of Federal health reform legislation, the development of a large, well trained workforce of health care professionals will be a critical component in ensuring that newly-covered individuals, and all New Yorkers, are able to access care. ACA includes a number of provisions that allow states to expand and reinforce the health care workforce to meet increased demand for health care services, with a particular emphasis on primary care and nursing in all specialties.

Provisions to Facilitate the Planning and Implementation of Workforce Development Strategies (§ 5102)

ACA includes provisions that seek to enable the planning and implementation of workforce development strategies at the national, state, and local levels. A new National Healthcare Workforce Commission is charged with reviewing current and projected health care workforce supply and demands, and making recommendations to Congress and the administration around health care workforce priorities and policies. ACA also establishes the National Center for Healthcare Workforce Analysis to develop data and analysis to support health care workforce investment decisions. These initiatives will extend to the state level through two grant programs:

STATE HEALTH CARE WORKFORCE DEVELOPMENT COMPETITIVE GRANT PROGRAM

- Eligible entities include state workforce investment boards that establish partnerships with key stakeholder groups.
- One-year planning grants ($150,000 each with a 15% match requirement).
- Two-year implementation grants (25% match requirement).

STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS GRANTS

- Eligible entities include a state, a state workforce investment board, a public health or health professions school, an academic health center, or other appropriate public or private nonprofit entity.
- The grants will support workforce data collection, analysis, reporting, and technical assistance needs at the local and state levels.

Provisions to Increase the Supply and Enhance the Training and Education of Health Care Professionals

Federal health reform includes a number of provisions focused on increasing the supply of health care professionals to meet increased demand for health care services and enhancing the training and education of the health care workforce with a particular emphasis on public health.

TABLE 17. ACA Scholarships and Loan Programs

SECTION	PROGRAM	FEDERAL FUNDING	ELIGIBLE ENTITIES
5201	Federal Health Professionals Student Loan Program Modifications		
5202	Nursing Student Loan Program	Not specified	
5203	Pediatric Specialties Loan Repayment Program	$210 million	Eligible Professionals
5204	Public Health Workforce Loan Repayment Program	At least $195 million	
5205	Allied Workforce Loan Repayment Program		Allied Health Professionals
5206	Mid-Career Allied Health Scholarships Grant Program	$30 million for 2010 and additional sums as necessary through 2014	Eligible Professionals
5206	Scholarships for Federal, State, and Local Officials for Public and Allied Health Training	$30 million for 2010 and additional sums as necessary through 2014	Accredited educational institutions
5207/10503	National Health Service Corps	Up to $4 billion between 2010 and 2015, with continued funding in 2016 and beyond. Supplemental funding of $1.5 billion between 2011 and 2015.	
5305	Geriatric Career Incentives Grant	$10 million	Eligible Professionals
5311	Nursing Faculty Loan Program	Not specified	Nursing Schools

Training and Education Grants. ACA authorizes the distribution of a number of training and education grants that address the need to ensure improved quality of care through the effective education and training of health care professionals. Grant programs created or modified by ACA are outlined in Table 18.

TABLE 18. ACA Training and Education Grants

SECTION	GRANT PROGRAM	FEDERAL FUNDING	ELIGIBLE ENTITIES
5301	Primary care training programs[82]	$125 million for 2010 and additional sums as necessary through 2014	A public or nonprofit hospital, medical school, physician assistant training program, or public or nonprofit entity
5302	New training programs for direct care workers in long-term care settings	$30 million	Higher education institutions
5303	Dentistry training programs	$30 million for 2010 and additional sums as necessary through 2014	Higher education and health care provider institutions
5304	Alternative dental health care provider demonstration project	$300 million	Safety net providers or higher education institutions

continued on next page ▶

[82] HHS released a grant funding announcement for this and other programs on June 16, 2010. See http://www.hhs.gov/news/press/2010pres/06/20100616a.html.

TABLE 18. ACA Training and Education Grants

SECTION	GRANT PROGRAM	FEDERAL FUNDING	ELIGIBLE ENTITIES
(CONTINUED) 5305	Geriatric education center fellowship programs	$10.8 million	Higher education and/or health care provider institutions
5306	Mental and behavioral health training programs	$35 million	Higher education institutions
5307	Development of training curricula related to cultural competency, prevention, public health, and working with individuals with disabilities	Appropriations as necessary	As determined by the Secretary
5309	Nurse retention improvement initiatives and programs to promote nurse involvement in clinical decision-making processes	Appropriations as necessary	Nursing schools and/or health care facilities
5313	Community health worker training programs	Appropriations as necessary	Public or nonprofit private entity, including a state, public health department, free health clinic, hospital, or FQHC
5314	Public health fellowship training	$158 million	Expansion of existing programs
5316	Demonstration grants for family nurse practitioner training programs	Appropriations as necessary	FQHCs and nurse-managed health clinics who employ nurse practitioners
5402	Health professions training for diversity	$60 million for 2010 and additional sums as necessary through 2014	Disadvantaged students who commit to work in Medically Underserved Areas and faculty positions
5507	Demonstration projects to address health professions workforce needs (occupational health and personal and home aides)	$85 million	1. Demonstration project for up to six states 2. Demonstration for wide range of entities able to manage and evaluate such a demonstration
5508	Teaching health centers development (for the purpose of establishing new accredited or expanded primary care residency programs)	$125 million	Community-based health centers
5509	Graduate nurse education demonstration program (Medicare)	$200 million	Up to five hospitals
10501	Preventive medicine and public health residency programs	$43 million for 2011 and additional sums as necessary through 2015	State health departments, higher education institutions, health care institutions
10501	Rural physician training	$16 million	Higher education institutions

Payment and Delivery System Reform

ACA includes pilots and demonstration projects intended to test and rapidly deploy new care and payment models that reduce health care costs and improve quality of care for Medicaid and Medicare beneficiaries, dual eligible New Yorkers, and by virtue of their broad application across the health care delivery system, all consumers of health care in New York State. Several of these new initiatives are centered on state Medicaid programs, and many require or encourage active state partnership with care providers. These new opportunities for states to drive value in the health care delivery system through reducing unnecessary costs and improving clinical outcomes will require high-level strategy, planning, implementation infrastructure, and nimble evaluation and deployment capacities at the state level.

The newly created CMS Center for Medicare and Medicaid Innovation (described below) will oversee the implementation and evaluation of the demonstration projects at the Federal level and the HHS Secretary has been given new authority to expedite the expansion of programs. But, states will be responsible for on-the-ground deployment and evaluation, and ultimately will have a key role in identifying effective models of care delivery and deploying them across multiple providers and payers. Additionally, because many of the demonstrations required by ACA involve multiple care providers across the continuum of care and introduce new payment methodologies, states—including New York—will face significant implementation challenges.

Following is an overview of key programs providing significant funding opportunities for New York.

MULTI-PAYER DELIVERY SYSTEM REFORM INITIATIVES

The ACA creates two new Federal entities charged with driving health care reimbursement and delivery system reform in both Medicaid and Medicare.

Center for Medicare and Medicaid Innovation (§ 3021)

ACA provides $10 billion over 10 years to establish by January 1, 2011 a new Center for Medicare and Medicaid Innovation (CMI) within CMS. CMI's charge is to develop, evaluate, and where warranted, expand innovative payment and delivery system models that reduce Medicare and Medicaid expenditures while preserving or enhancing quality of care. CMI will focus on populations for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The law requires the CMI to consult with representatives of relevant Federal agencies and clinical and analytical experts in medicine and health care management to carry out its duties. CMI is also directed to use open door forums or other mechanisms to seek input from interested parties.

The new law outlines 20 patient care and payment reform innovation models for CMI's consideration, but authorizes the HHS Secretary to select additional or alternative pilots that would advance the goals laid out above. The models are designed to support the development and use of medical homes, coordinated care strategies, and more effective post-acute hospital

services, with a particular focus on comprehensive and salary-based payment structures as alternatives to fee-for-service based reimbursement. These models would incentivize professional and institutional collaborations, encourage the use of evidence-based standards, and allow greater flexibility to reward innovation. In addition, states would have the flexibility, by working with CMI, to integrate care for "dual eligibles," or individuals who are covered by both Medicaid and Medicare, by assuming the management and oversight of both Federal funds for Medicare and Medicaid services, as well as state funds for services covered by Medicaid and other state-based programs. States would also have the flexibility to test and evaluate all-payer systems of reform.

Federal Coordinated Health Care Office (§ 2602)

For better integration of service delivery and payment mechanisms for dual eligibles, ACA directs the establishment of the Federal Coordinated Health Care Office within CMS to facilitate a working relationship between Medicare and Medicaid at the Federal level and Medicaid offices at the state level. The new office is specifically charged with ensuring that these beneficiaries have better access to all services to which they are entitled and improved quality of health care and long-term care services. Specific responsibilities of the Coordinated Health Care Office include:

- providing states and other relevant parties with education and tools for developing programs that align Medicare and Medicaid benefits for dual eligibles;
- supporting state efforts to coordinate and align acute and long-term care services for dual eligibles with other Medicare benefits;
- supporting coordination of contracting and oversight by the states and CMS;
- consulting and coordinating with the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC);
- studying the provision of drug coverage for new full-benefit dual eligibles; and
- monitoring and reporting total expenditures, health outcomes and access to benefits for all dual eligibles.

MEDICAID DELIVERY SYSTEM REFORM OPPORTUNITIES

The ACA establishes several new Medicaid-related demonstration projects, grant programs, and state options. Several of these new opportunities will become available onJanuary 1, 2011, and some have the potential to bring new Federal funding to New York State. For each of these new projects and funding opportunities, New York State faces significant tactical work that must be managed, including:

- strategic analysis, request for proposals (RFP) submission (and potential State-level RFP creation or application process development for state providers);
- harmonization of regulations and possible legislative changes, most notably with respect to licensure and rate setting requirements;

- data collection;
- project monitoring and evaluation; and
- broad, rapid expansion across Medicaid, CHPlus, and possibly a Basic Health Program, of those efforts likely to yield a positive return on investment.

Further, the State faces a range of implementation issues. Most significantly, New York must determine how these program innovations can be implemented within—or coordinated with—the State's Medicaid managed care program and existing demonstration projects, including the State's Medical Home Demonstration. New York's immediate task will be to consider how these new program opportunities may influence current operations and planning, with an eye to demonstrating readiness and leveraging current operations to attract new funding as these initiatives are implemented at the Federal level.

Payment Adjustment for Health Care-Acquired Conditions (§ 2702)

Effective July 1, 2011, ACA prohibits state Medicaid programs from paying for services that relate to health care-acquired conditions (HACs)—preventable conditions resulting from treatment in a hospital.[83] The Secretary is charged with promulgating regulations that define HACs based on Medicare definitions and current state practices. New York is one of only 12 states to have implemented a statewide "never event" program in Medicaid to prohibit payment for HACs, and will likely need to cross-walk HAC regulation with its existing "never event" policy in Medicaid and align state policy with new Federal regulations, as required.

Elective Demonstration and Pilot Opportunities

State option to provide health homes for enrollees with chronic conditions (§ 2703). Beginning on January 1, 2011, states will have the option to amend their Medicaid state plans to create health homes for people with chronic conditions who are covered by Medicaid, including dual eligibles. This demonstration is designed to promote a coordinated, team-based approach to providing health care to individuals with multiple, chronic illnesses.

Through the demonstration, eligible consumers select a provider or a team of health care professionals as their health homes. The designated provider or team health home would provide comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and, as feasible, use health information technology to link such services. Medicaid beneficiaries eligible for the demonstration include those who have:

- at least two chronic conditions;
- one chronic condition and at risk of developing another; or
- at least one serious and persistent mental health condition.

[83] A HAC is defined as "a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in § 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv))."

Qualifying providers would have to meet certain standards established by HHS, including demonstrating that they have systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. Teams of providers could be freestanding, virtual, or hospital-based. They could also be community health centers, community mental health centers, clinics, physician's offices, or physician group practices. Designated providers would be required to report to the State on all applicable quality measures in the State Medicaid program.

ACA provides an enhanced match of 90% FMAP for all Medicaid costs for health home enrollees for the first two years of program operation. Small planning grants may also be available to states beginning in 2011.

The health home option has the potential to provide additional financial resources to Medicaid providers for coordinating care for Medicaid beneficiaries with chronic conditions. If New York opts to participate in the program, payment could be structured to fund a broader set of professional services and patient supports than are currently reimbursed in the fee-for-service Medicaid program. For its part, New York State Medicaid will seek a return on investment for the more expansive service and payment model in the form of quality improvement, better clinical outcomes, and long-term avoidance of acute, episodic care and related costs. Enhanced FMAP will bolster the State's ability to fund the new care model in the short term, but such funding will only be sustainable in the long term if the health home program has demonstrable success.

New York also has an existing patient-centered medical home program authorized by Chapter 58 of the Laws of 2009, which applies to providers that serve both Medicaid fee-for-service and managed care enrollees. This program includes a financial incentive for providers who meet medical home standards, with the goal of improving health outcomes through better coordination and integration of patient care for individuals enrolled in New York Medicaid. The State Department of Health is in the process of implementing the initiative and recently received CMS approval to implement the program with office-based practitioners, FQHCs, and diagnostic and treatment centers (D&TCs).[84] The State chose to adopt medical home standards that are consistent with those of the National Committee for Quality Assurance's (NCQA's) Physician Practice Connections®—Patient-Centered Medical Home Program (PPC-PCMH™). While additional guidance is required from HHS regarding particulars of the ACA health home for enrollees with chronic conditions, the program promises to be a strong complement to New York's existing plans, and New York Medicaid's choice to model its medical home program around accepted national standards may make it easier to harmonize Federal program requirements.

[84] New York State Department of Health. Medicaid Update. Vol 26; No 7. May 2010.

STATE IMPLEMENTATION: CHART 20. State Option to Provide Health Homes for Enrollees with Chronic Conditions	
SUMMARY	ACA authorizes a new state plan option under which eligible Medicaid enrollees with chronic conditions, including dual eligibles, could designate a provider or health team as their health home. The health home would be responsible for providing comprehensive medical and care coordination services.
EFFECTIVE DATE	January 1, 2011: State option available and HHS may award planning grants to states for the purposes of developing a state plan amendment to create health homes.
FEDERAL FUNDING	▸ States opting to create the program would receive an enhanced match of 90% FMAP for two years. ▸ The law allocates $25 million for small planning grants to help states intending to take the option. FMAP rules would apply.
RESPONSIBLE PARTIES	▸ CMS will issue guidance to states on the new state option. ▸ Secretary of HHS is required to survey states and report to Congress. ▸ New York State Department of Health. ▸ New York State Legislature.
STATE IMPLEMENTATION TASKS/ISSUES	**Tasks** ▸ Amend State Plan to provide health home services to chronically ill persons covered by Medicaid and articulate plan for tracking program outcomes. ▸ Apply to HHS for planning grant and secure funding for State match. ▸ Develop provider health home payment mechanism. ▸ Develop mechanisms to segment eligible beneficiaries. ▸ Establish a tracking mechanism for health home quality reporting. **Issues** ▸ How will the program be integrated with New York's existing medical home program? ▸ How will beneficiaries be segmented for health home participation from the Medicaid managed care and/or Medicaid fee-for service programs?

Pediatric Accountable Care Organization Demonstration Project (§ 2706). Beginning on January 1, 2012 and through December 31, 2016, ACA establishes a new demonstration to allow pediatric providers to form Accountable Care Organizations (ACOs). ACOs represent a new category of contractors created by ACA that are able to share in program savings that result from using new patient care models that coordinate care. ACO requirements articulated in ACA include clinical and administrative systems needed to support evidence-based medicine, coordinated care—including the use of telehealth and other enabling technologies—and the ability to report quality and cost measures and to meet patient-centeredness criteria, such as the use of patient and caregiver assessments or the use of individualized care plans.[85] States may seek participation in this demonstration through an application process to be developed by the Secretary.

The Pediatric ACO demonstration opportunity raises significant implementation questions for New York where the vast majority of children covered by public health insurance are enrolled in either a Medicaid managed care or Child Health Plus plan. Roughly 20 health plans throughout the State receive capitated premium payments for managing and arranging care for more

[85] § 3022.

than 2 million children. A major challenge for New York with respect to pursuing the Pediatric ACO program would be how to integrate the program with the State's extensive managed care infrastructure, or whether plans themselves are not, in effect, ACOs.

Demonstration project to evaluate integrated care around a hospitalization (§ 2704). ACA directs the Secretary to establish a demonstration project to evaluate the use of bundled payments in Medicaid for the provision of integrated care during an episode of care, including a hospital stay and concurrent physician services provided during hospitalization. The demonstration is effective on January 1, 2012 through December 31, 2016, and is limited to eight states to be selected by the Secretary through a competitive application process.

The Secretary is given authority to waive any Medicare or Medicaid provision of Title XI of the Social Security Act to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care. A state selected to participate in the demonstration project may target the project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State. A state selected to participate in the demonstration project must specify the one or more episodes of care the state proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. To participate in this program, New York would have to determine not only the service definition of bundled payments, but also how to cross-walk provider and beneficiary participation across both the fee-for-service and Medicaid managed care programs. The state would have to evaluate whether a managed care population demonstration should be conducted in partnership with Medicaid managed care plans or whether this demonstration would be tested in the fee-for-service program only.

Provider and Consumer Targeted Grant Programs to Support Medicaid Reform

Quality improvement technical assistance grants (§ 3501). ACA authorizes technical assistance grants to provider organizations, provider associations, and other entities for the purpose of offering technical assistance to providers for quality improvement activities. Grants will be awarded based on applications. Federal funding must be matched by grantees at a ratio of $1 from the grantee: $5 from the Federal government.

Community health teams to support the patient-centered medical home (§ 3502 as modified by § 10321). ACA establishes a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grantees must submit a plan for achieving long-term financial sustainability within three years, and incorporate prevention initiatives and patient education and care management resources into the delivery of health care that are integrated with community-based prevention and treatment resources, where available, with a focus on chronic conditions.

Medication management for individuals with chronic diseases (§ 3503). The HHS Secretary, acting through the newly established Patient Safety Research Center, is authorized to establish a program to provide grants for medication management services provided by licensed

pharmacists and targeted to people with chronic illnesses. The goal of the grant program, which the HHS Secretary was directed to launch by May 1, 2010, is to improve the quality of care and reduce overall cost in the treatment of chronic diseases. New York has an existing pilot, called the medication therapy management program, which serves Medicaid beneficiaries with certain chronic illnesses. New York State's program appears consistent with the ACA initiative; New York may seek a grant to support and expand existing program operations.

Expansion of the Patient Navigator Program (§ 3510). ACA also reauthorizes demonstration programs to provide patient navigator services within communities to assist patients with overcoming barriers to health services by coordinating health services and provider referrals, assisting community organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations starting as early as 2010.

MEDICARE DELIVERY SYSTEM REFORM OPPORTUNITIES

The ACA also provides authority and funding for numerous Medicare grant and pilot programs to promote delivery system innovation.

Medicare Shared Savings Program/Accountable Care Organizations (§ 3022). A new Medicare Shared Savings Program authorized by the ACA will be established in January 2012 to promote accountability for providing high-quality and efficient health care services to a defined population of patients. Through the program, Accountable Care Organizations (ACOs) that meet quality targets established by the Secretary will be able to receive savings that result from a reduction in the average per capita costs for an assigned population of Medicare enrollees compared to a target per capita rate established by the Secretary. A participating ACO must be willing to become accountable for the quality, cost, and overall care of its enrolled Medicare fee-for-service beneficiaries, and must participate in the program at least three years. Providers and insurers may seek participation in this demonstration through an application process to be developed by the Secretary.

Payment Bundling Pilot (§ 3023). A five-year pilot program, the payment bundling pilot would create episode of care payments for acute care services provided to Medicare beneficiaries with one or more of 10 chronic conditions. Payments would include pre-admission services provided in the three days prior to hospitalization, hospital services, and 30 days of post-discharge services. Bundled services will be determined by the Secretary of HHS, but will include acute care, inpatient and outpatient physician services, outpatient care, home health, and long-term care. Provider organizations participating in the pilot will be required to submit data on quality measures that will be used to evaluate program efficacy.

Hospital Readmissions (§ 3025). Effective October 1, 2012, Medicare will reduce payments to hospitals with high rates of readmissions for three high-volume, high-cost conditions when patients are admitted within 30 days of discharge. This reform to hospital reimbursement will require hospitals to implement or enhance community-based care transition efforts designed to reduce readmissions and avoid financial penalties.

Community-Based Care Transitions Program (§ 3026). The ACA provides $500 million to establish collaborative partnerships between hospitals with high readmissions and community-based organizations. The program will encourage evidence-based care transitions services for Medicare beneficiaries at high-risk for hospital readmission. HHS will prioritize entities that serve medically underserved populations, small communities, and rural areas.

DUAL ELIGIBLES

The ACA includes provisions targeted to integrating and coordinating care for dual eligibles—generally low-income seniors and people with disabilities. Dual eligibles are the most medically complicated and expensive populations for both Medicaid and Medicare; yet, 80% of these beneficiaries receive their care through uncoordinated fee-for-service models.[86] Financial and administrative responsibility for dual eligibles care is fragmented, leading to significant access and quality issues for people who rely on both Medicare and Medicaid for services.

New York has approximately 650,000 dual eligibles enrolled in its Medicaid program, the second highest number of dual beneficiaries in the country after California. While dual eligibles represent just 16% of New York's Medicaid beneficiaries, they generate 40% of total expenditures, or $16 billion annually.[87] Nationally, more than half of Medicaid expenditures for dual eligible beneficiaries are related to long-term care services.[88] Several health insurance models operate in New York State are designed to integrate payment and coordinate benefits for dual eligible individuals. These programs include:

- ***Medicaid Advantage:*** a Medicaid managed care companion program to Medicare Advantage (Medicare managed care) that allows beneficiaries to enroll in the same health plan for most of their Medicare and Medicaid benefits, excluding long-term care.
- ***Medicaid Advantage Plus:*** a Medicaid Advantage program that covers long-term care services.
- ***Program for All-Inclusive Care for the Elderly (PACE):*** a national managed care program for people who require long-term care, but wish to remain in their communities and receive adult day care services. PACE covers all medical needs for its enrollees.

Enrollment in these programs is voluntary and, to date, they collectively cover a relatively small number of New Yorkers: 8,574 or 1.3% of full dual eligibles in the State.[89] The balance of dual eligible individuals in New York is served through a Medicaid's fee-for-service program.

New York is in the early stages of developing a "Federal-State Medicare Shared Savings Partnership" waiver to seek Federal approval to allow the State to implement a series of

[86] Center for Health Care Strategies. Options for Integrating Care for Dual Eligible Beneficiaries. March 2010. Available at: http://www.thescanfoundation.org/sites/default/files/CHCS%20Options%20for%20Integrating%20Dual%20Eligible%20Care.pdf.

[87] Kissinger, M. "New York State Department of Health Office of Long Term Care: 2010-11 Executive Budget Summary" Presentation at the New York State Public Welfare Association. January 27, 2010.

[88] Kaiser Family Foundation. Kaiser State Health Facts. Distribution of Medicaid Spending for Dual Eligibles by Service (in millions), 2005.

[89] Kaiser Family Foundation. Kaiser State Health Facts: New York State. Dual Eligible Enrollment, 2005. Full dual eligibles are defined as qualifying for full Medicaid benefits, including long-term care provided in both institutions and in the community as well as prescription drugs. For this group, Medicaid may also pay Medicare premiums and cost-sharing.

demonstration proposals to integrate care for dual eligible New Yorkers, and share in the Medicare savings generated through these initiatives.[90] The State Legislature enacted law in June 2010 authorizing the State to develop the partnership program.

TABLE 19. New York State Programs for Dual Eligibles

PROGRAM	ENROLLMENT
Medicaid Advantage	5,639
Medicaid Advantage Plus	531
PACE	3,405

Source: New York State Monthly Managed Care Enrollment Report, May 2010

ACA provides a policy mandate and framework for CMS to drive integration and coordination of care for dual eligibles. The law provides opportunities for New York to make delivery system improvements for dual eligibles through enhanced Federal funding, technical support, and rapid deployment and testing of innovation. The changes in ACA appear to be aligned with New York's goals and objectives in its planned Federal-State Medicare Shared Savings Partnership waiver, and may enable the State to more rapidly deploy a strategy with respect to care and funding integration for dual eligibles.

Five-Year Period for Dual Eligible Demonstration Projects (§ 2601)

New waiver demonstration authority is created for states to conduct five-year waivers related to dual eligible beneficiaries under Social Security Act § 1115 Research & Demonstration Projects, § 1915(b) Managed Care/Freedom of Choice Waivers, § 1915(c) Home and Community-Based Services Waiver, and § 1915(d) Waivers. This provision authorizes dual eligible waivers to be conducted over longer periods of time to allow states to capture longer-term savings. These waiver programs are currently two- to three-year initial authorization periods, with a maximum three-year renewal.

Extension of Special Needs Plan (SNP) Program (§ 3205)

ACA extends SNP program authority through December 30, 2013 and allows HHS to apply a frailty payment adjustment to fully integrated, dual eligible SNPs that enroll frail populations. The law also requires dual eligible SNPs to contract with state Medicaid programs beginning 2013. Finally, ACA requires SNPs to be NCQA-approved.

LONG-TERM CARE

ACA includes several provisions targeted to making long-term care accessible and affordable and to shift care from institutional to community settings to the largest extent possible. The law creates the nation's first government–sponsored, long-term care insurance program, and provides authority and funding for a series of projects and pilot programs that develop, integrate, and pay for home- and community-based long-term care services.

[90] Kissinger, M. "New York State Department of Health Office of Long Term Care: 2010–11 Executive Budget Summary" Presentation at the New York State Public Welfare Association. January 27, 2010. Spending includes long-term care expenditures related to OMRDD related services.

In 2009, long-term care spending in New York's Medicaid program was $12.3 billion, 28% of total Medicaid expenditures for the year.[91] New York has several programs and demonstrations that promote long-term care reform goals that are consistent with the goals of ACA. The State operates the Long Term Home Health Care Program (LTHHCP), a Social Security Act § 1915(c) Home and Community Based Medicaid waiver program serving seniors and individuals with disabilities who are medically eligible for nursing home care, but seek to remain in their communities. LTHHCP provides care coordination and supportive services through a network of contracted agencies. The program serves 24,000 individuals throughout the State.[92]

More recently, the New York State Department of Health launched several initiatives to reform the State's long-term care delivery system, including:

- ***The Nursing Home "Rightsizing" Demonstration:*** Allows nursing homes to convert beds to long-term care home health, adult day care and/or assisted living "slots." The agency is seeking CMS authority to expand the demonstration from 2,500 to 5,000 beds.
- ***County Long-Term Care Demonstration:*** A five-county demonstration to promote conversion of county nursing homes to alternative long-term care settings.
- ***Money Follows the Person Rebalancing Demonstration:*** Provides the State with $4.7 million annually in additional FMAP funding to assist individuals in avoiding long-term care institutionalization and transitioning from nursing home to community-based settings.

ACA includes a number of key long-term care provisions that align with and support New York's current approach to restructuring long-term care delivery, and provide new funding to expand LTC reform efforts in the State.

CLASS Program (§ 8001)

The health care reform law establishes a new, national and voluntary long-term care insurance program called the Community Living Assistance Services and Supports (CLASS). The program is designed to promote independent and community-based living for older adults and individuals with disabilities through financial assistance. Participants become eligible for the program after contributing premiums for five years (either directly or through payroll deductions initiated by an employer). Once eligible, participants will receive at least $50 per day paid, either daily or weekly, to support needs, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Institutionalized residents are eligible for the payment; all but 5% of the benefit will go toward payment of the institutional care. Individuals enrolled in Medicaid home- and community-based services, or the PACE program, will similarly be eligible for the payment; 50% of the payment will go to the State to cover the cost of care.[93]

New York currently operates the Partnership for Long-Term Care, a program originally funded by the Robert Wood Johnson Foundation, which combines long-term care insurance and Medicaid

[91] Kissinger, M. "New York State Department of Health Office of Long Term Care: 2010-11 Executive Budget Summary" Presentation at the New York State Public Welfare Association. January 27, 2010.

[92] Hokenstad, A., Shineman, M., and Auerbach, R. An Overview of Medicaid Long-Term Care Programs in New York. United Hospital Fund. April 2009.

[93] Effective dates of this program vary. While tax treatment of the program begins January 1, 2011, HHS Secretary must design an eligibility assessment program by January 1, 2012.

Extended Coverage. Its purpose is to help New Yorkers financially prepare for the possibility of eventually needing nursing home care, home care, or assisted living services. The program allows New Yorkers to protect some or all of their assets (resources), depending on the insurance plan purchased, if their long-term care needs extend beyond the period covered by their private insurance policies. New York will likely seek to re-evaluate and possibly align or integrate its current Partnership for Long-Term Care program with the new Federal CLASS program.

Payment and Care Delivery Demonstration, Grant, and Pilot Programs

ACA provides new plan options and demonstration programs to encourage and incentivize State innovation in payment reform, and delivery system integration in long-term care and care for dual eligible beneficiaries. CMS will provide guidance on the structure of these programs. New York State will need to determine how it can best leverage these programs to support its existing and planned demonstrations, and maximize Federal funding for additional long-term care delivery system innovations.

TABLE 20. New State Options and Demonstration Programs Related to Long-Term Care Available under Health Reform

PROGRAM OPTION	DESCRIPTION	NEW FEDERAL FUNDS	EFFECTIVE DATE
Medicaid Community First Choice Option § 2401	State plan amendment option to provide coverage of home- and community-based attendant services and supports, such as assistance to accomplish activities of daily living, to those who meet the State's nursing facility clinical eligibility standards. Threshold issues for New York with respect this option include determining whether the State's current personal care program qualifies for reimbursement under this program.	6% FMAP increase	October 1, 2011
Home- and Community-Based Services State Plan Options § 2402	Provision simplifies home- and community-based services through a State plan option rather than pursuing more onerous Federal waiver authority. Provides a full range of Medicaid services to individuals whose income does not exceed 300% of the Supplemental Security Income (SSI) standard.	Regular match rate	April 1, 2010
Balancing Incentive Payments Program § 10202(a)	Expands and diversifies Medicaid coverage for home- and community-based long-term care services (HCBS) and makes structural changes to improve coordination and access to such services. Creates new financial incentives for states to shift Medicaid beneficiaries out of facilities and into HCBS. Only states with less than 50% of long-term care being provided in community-based settings will be eligible to participate in this program, with further guidance expected from HHS on the definition of "community-based." Whether New York will meet this threshold will depend on the definition of community-based long-term care, as well as the populations included in the calculation, pursuant to HHS guidance.	2–5% FMAP increase Allocates up to $3 billion for Medicaid home- and community-based services.	October 1, 2011 through September 30, 2015

continued on next page ▶

TABLE 20. New State Options and Demonstration Programs Related to Long-Term Care Available under Health Reform

PROGRAM OPTION	DESCRIPTION	NEW FEDERAL FUNDS	EFFECTIVE DATE
(CONTINUED) Medicaid Money Follows the Person (MFP) Rebalancing Demonstration § 2403	Demonstration established through the Deficit Reduction Act of 2005 (P.L. 109-171) to reduce reliance on institutional care and develop community-based systems of care. ACA modifies eligibility rules to require that individuals reside in an inpatient facility for no fewer than 90 days. New York receives $4.7 million annually for the Nursing Home Transition and Diversion program, for the five-year project term from 2008–2012. The project aims to transition 2,800 individuals from institutional to community-based settings. On June 22, 2010, CMS released a State Medicaid Director letter that provides clarification and guidance on the MFP Demonstration Program. Benefits of the ACA MFP Demonstration Program provisions to states like New York that are already participating in the program include: Enhanced FMAP for home- and community-based services and demonstration services; use of the American Recovery and Reinvestment Act of 2009 enhanced FMAP rate as the base from which to calculate states' MFP-enhanced FMAP rate through December 31, 2010, subject to a 90% cap; technical assistance (TA) provided by CMS contracted experts in the long-term care; HCBS and demonstration services reimbursed at the enhanced MFP FMAP; supplemental services reimbursement for services only be available for the MFP Demonstration Program period and not covered by Medicaid; and full reimbursement for certain MFP Demonstration administrative costs, including key personnel; MFP travel, training, outreach and marketing; IT infrastructure to accommodate the MFP reporting requirements; and completing the Quality of Life survey requirements. CMS will post a grant solicitation in summer 2010 to www.grants.gov to offer states not currently participating the opportunity to apply for an MFP Demonstration Program Grant through a competitive award process.	ACA extends demonstration through September 30, 2016, bringing new aggregate Federal funding of $450 million each year for FY 2011–2016.	30 days after enactment of ACA (April 22, 2010)

Sources: Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); The Scan Foundation, Policy Brief No. 2. March 2010.

Appendix

ELIGIBILITY AND COVERAGE ESTIMATE METHODOLOGY

The eligibility estimates for this report were produced by first estimating a baseline population of non-elderly uninsured in New York State, then distributing this pre-reform uninsured population by eligibility group based on a combination of widely published estimates of Medicaid eligible, but uninsured, populations, and supplemented by original analysis of the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). Coverage projections were then developed based on previously published research for the eligibility groups where published estimates exist, and a combination of previously published information and original research for the eligibility groups where no applicable and reliable estimates have yet been released.

Baseline New York State Non-Elderly Uninsured Population Pre-Reform

The baseline population of New York State non-elderly uninsured (age 0–64) is derived from the 2009 CPS ASEC, reflecting 2008 population data.[94] This baseline population of uninsured was adjusted in two ways:

- Uninsured population was adjusted downward by 2.4% to control for the undercount of public coverage, based on United Hospital Fund (2010) methodology.[95]
- The uninsured population was adjusted upward by 1.3% to reflect the undercount of undocumented uninsured, based on the work of Jeffrey Passel and colleagues.[96]

Distribution of Pre-Reform Uninsured Population by Eligibility Group

The estimated distribution of the baseline population by eligibility group is derived from a combination of widely published estimates of Medicaid eligible but uninsured populations, and supplemented by original analysis of the CPS ASEC. For purposes of estimating the population by eligibility group, distribution of segments of the uninsured population by age, family composition and income were derived from a three-year blend of CPS ASEC data (2007–2009) to obtain adequate sample sizes. The non-elderly uninsured population was estimated for five eligibility groups relevant to estimating the coverage impacts of Federal reform:

Undocumented Uninsured: Undocumented uninsured were estimated based on the work of Jeffrey Passel and colleagues.[97] Note that these estimates of the undocumented do include PRUCOL immigrants, some of whom may in fact be eligible for benefits under ACA.[98]

[94] US Census Bureau. 2009 Current Population Survey, Annual Social and Economic Supplement. Available at: http://www.census.gov/cps.

[95] Holahan, Danielle, Allison Cook and Emily Lawton. Heatlh Insurance Coverage in New York, 2008. United Hospital Fund, June 2010. Available at: http://www.uhfnyc.org/assets/819.

[96] Passel, Jeffrey. Unauthorized Migrants: Numbers and Characteristics. Pew Hispanic Center. June 14, 2005; Passel, J. The Size and Characteristics of the Unauthorized Migrant Population in the U.S. Estimates Based on the March 2005 Current Population Survey. March 2006. Available at: http://pewhispanic.org/files/reports/46.pdf.

[97] Passel (2006), and Hoefer, M, Rytina, M, Campbell, C. Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2006. Available at: http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2007.pdf.

[98] PRUCOL immigrants are not distinguished in this analysis, as they are not distinguishable in Passel's methodology and supplemental reliable information about the size and characteristics of this group is not otherwise available. However, it is worth noting that in practice they may look somewhat different from the undocumented population in their coverage patterns and access to coverage, particularly due to their eligibility for Medicaid in New York State. Additionally, preliminary analysis of ACA suggests that PRUCOL immigrants may be eligible to purchase coverage in New York's health insurance exchange or may have access to other benefits under Federal reform, though the interaction of ACA provisions and PRUCOL status is not clear at this time.

Medicaid Eligible but Uninsured: The population of pre-reform Medicaid eligible, but uninsured, is estimated as 42.1% of the total uninsured population, based on widely accepted analyses published by the Kaiser Family Foundation (2010)[99] and the United Hospital Fund (2010).[100]

Remaining Uninsured Population Distribution by Income and Family Composition: The remaining non-elderly uninsured population (total estimated uninsured population minus estimated undocumented uninsured and pre-reform Medicaid eligible uninsured) was distributed among the three remaining eligibility groups (Newly Medicaid Eligible, Subsidy-Eligible, and Ineligible for Medicaid or Subsidy) based on the relative size of the three groups in the CPS ASEC three-year blend as described above and defined by income level and family composition (100–133% FPL for single adults, 133–400% FPL for all adults, and more than 400% FPL for adults and children, respectively).[101]

Post-Reform Coverage Estimates by Eligibility Group

Post-reform coverage estimates were derived for each eligibility group, based as much as possible on previously published estimates of ACA coverage impacts, and supplemented by original analysis where relevant and where applicable published estimates do not exist. These estimates reflect projected coverage for the 2008 New York State non-elderly uninsured population.[102]

Undocumented Uninsured: We assume none of the undocumented gain coverage as a result of health reform, as they will not be newly eligible for Medicaid or subsidies and will not be allowed to obtain coverage through exchanges, nor would they be subject to individual mandate penalties.

Medicaid Eligible Uninsured: The Kaiser Commission on Medicaid and the Uninsured recently published state-by-state estimates of adult Medicaid take-up under health reform.[103] These published estimates include two take-up scenarios, "standard" and "enhanced." The projected take-up rates for currently Medicaid-eligible, but uninsured, under reform and newly Medicaid eligible populations under the two scenarios are as follows:

[99] Holahan, John and Linda Blumberg. How Would States Be Affected by Health Reform? Urban Institute, January 2010. Available at: http://www.urban.org/uploadedpdf/412015_affected_by_health_reform.pdf

[100] Holahan, Cook and Lawton (2010).

[101] US Census Bureau. 2007, 2008 and 2009 Current Population Survey, Annual Social and Economic Supplement. Available at: http://www.census.gov.

[102] These coverage estimates depend on the significant caveat that our analysis reflects projected coverage for the 2008 non-elderly uninsured population, held constant. The uninsured population is not trended forward to any future year, nor do our estimates reflect a prediction for any specific future year. Also, it is important to note that these estimates reflect the current (2008) uninsured only, and does not include any potential Medicaid or Exchange take-up from currently insured populations (i.e., possible crowd-out of ESI is not reflected). We also do not assume any other changes in ESI coverage.

[103] Holahan, John and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Kaiser Commission on Medicaid and the Uninsured. May 2010. Available at: http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

TABLE 21. Medicaid Take-Up Scenarios		
POST-REFORM TAKE-UP	KAISER STANDARD SCENARIO	KAISER ENHANCED SCENARIO
Medicaid Take-Up of Previously Eligible Uninsured	10%	40%
Medicaid Take-Up of Newly Eligible Uninsured	57%	75%

We apply these rates to our projected population of previously Medicaid eligible uninsured and newly Medicaid eligible uninsured, and report coverage results for each of the two scenarios.[104]

Subsidy-Eligible and Ineligible Uninsured Above Medicaid Levels: To estimate the post-reform coverage of the two remaining populations (the subsidy eligible population 133–400% FPL and the population above 400% FPL, which would be ineligible for Medicaid or subsidies), we estimated the number of individuals in these populations who would not obtain coverage, and consider the remainder to be those who would obtain coverage under reform. We considered two groups that would make up the vast majority of those above 133% FPL who would remain uninsured post-reform.

Penalty Payers: The vast majority of individuals above 133% FPL (well above the tax filing threshold) who would be ineligible for affordability waivers would be subject to a tax penalty if they fail to obtain health insurance coverage. Estimates of penalty payers are derived from published analysis from the Congressional Budget Office.[105]

Waived on Affordability Grounds: Coverage is considered unaffordable if it exceeds 8% of family income. Those for whom the lowest cost health insurance available to them equals more than 8% of family income are eligible for waivers exempting them from the individual coverage mandate. We estimate the size of this population, and make the conservative estimate that all of those eligible for the waivers take them. Our estimate of affordability waivers is based on original analysis, as—to our knowledge—no applicable estimates of projected affordability waivers have been published.

To calculate an estimate of affordability waivers, it was necessary to calculate a projected subsidy amount by income level that would be available to the uninsured under reform, and the lowest cost plan that would be available for purchase that would satisfy the ACA minimum benefit requirements. Both of these estimates derive from projected New York State exchange premiums.

As the baseline for our premium estimates, we used published FHPlus Employer Buy-In Small Group rates for 2010, trended forward to 2014 (when mandate provisions would go into effect).[106] These premiums represent the best available baseline to use in developing

[104] Note that there are very few Medicaid-eligible uninsured children in New York State, and little indication that their take-up rates would differ substantially from those of adults. As such, we did not adjust for the fact that our universe includes children age 0–18, simply applying Kaiser's rates to the entire population of Medicaid eligible uninsured age 0–64.

[105] Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Patient Protection and Affordable Care Act," April 22, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11355/Individual_Mandate_Penalties-04-22.pdf; Congressional Budget Office, "Letter to Honorable Nancy Pelosi," March 18, 2010. Available at: http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf.

[106] Statewide Family Health Plus Small Group premiums derived from New York State Department of Health, Family Health Plus Employer Buy-In Rate Sheets. 2009. Available at: http://www.health.state.ny.us/health_care/managed_care/family_health_plus_employer_buy-in/docs/premiums.xls; Conversations with Bela Gorman, Gorman Actuarial, May 2010.

exchange premium estimates for New York. We then adjusted the premiums down by 10% as an estimate of the share of premium costs that are related to State-mandated benefits that go beyond the minimum benefit package mandated in ACA.[107] We then estimated two New York State exchange premium levels: Bronze plan at .60 actuarial value, and Silver plan at .70 actuarial value.[108]

The exchange Bronze plan represents the lowest-cost qualifying plan, so if this plan is unaffordable (more than 8% of family income) then an individual or family would be eligible for a waiver from the individual coverage mandate. As such, we calculated whether the Bronze plan would be affordable at each income level using the ACA subsidy schedule, for an individual or for a family of four.[109]

Based on this analysis, we found that coverage would be affordable for all individuals and families eligible for subsidies.[110] For those above 400% FPL who are not eligible for subsidies, Bronze plan premiums become affordable at 550% FPL for an individual or 800% FPL for a family of four. We then estimate the share of uninsured children and non-elderly adults by income and family composition who would be below these thresholds, and project that this is the population that would not obtain coverage due to affordability waivers.[111]

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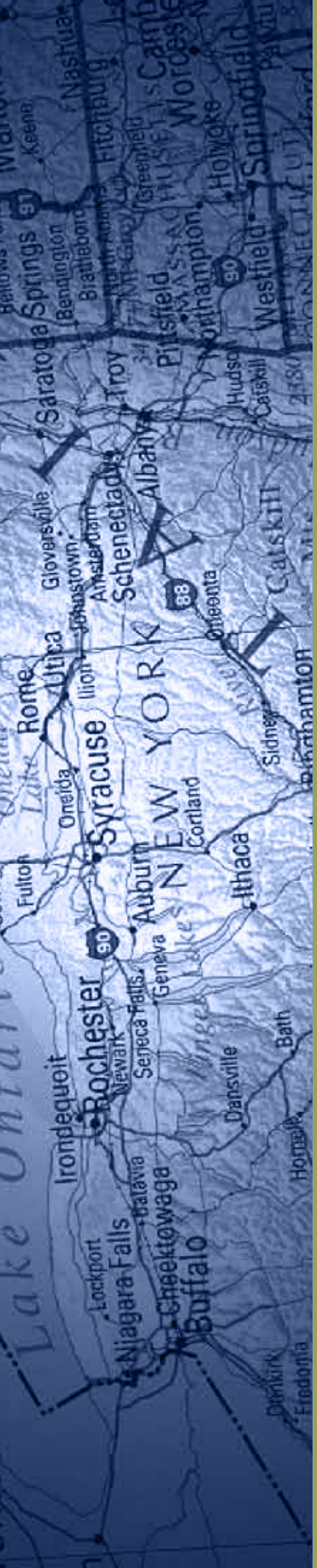
[107] New York State would be responsible for subsidizing the cost associated with these additional benefits, and as such the share of the premium cost that these benefits represent would not affect individual affordability.

[108] Based on published actuarial analyses, average actuarial value in the current NYS Small Group insurance market is estimated to be 0.86. To produce NYS Bronze and Silver plan premiums, we adjusted the estimated 2014 New York State Small Group premiums derived following the methodology above by a factor of 0.60/0.86 (Bronze Plan) or 0.70/0.86 (Silver Plan). Gorman Actuarial. Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools. United Hospital Fund. 2008. Available at: http://www.uhfnyc.org/assets/526, and Wellpoint, "New York Premium Impacts Analysis". 2009. Available at: http://www.wellpoint.com/pdf/New%20York%20Premium%20Impacts%20Analysis.pdf.

[109] Calculations are based on projected 2014 family income by FPL for an individual and a family of four.

[110] Subsidies under ACA are expressed as the cost of the second lowest cost Silver plan minus the family share, based on percentage of family income at each income level. As such, when these subsidies are used to purchase the lower-cost Bronze plan, subsidies are sufficient to make coverage affordable (less than 8% of family income) for all subsidy-eligible individuals and families below 400% FPL.

[111] Manatt original analysis of 2004-2006 Medical Expenditure Panel Survey. Available at: http://www.meps.ahrq.gov/mepsweb/.



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